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Use of guided imagery in Christian psychotherapy in treating minor depression in adults.

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USE OF GUIDED IMAGERY IN CHRISTIAN PSYCHOTHERAPY IN TREATING MINOR DEPRESSION IN ADULTS

A Dissertation Presented

by

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Dedication

To my Higher Power, whom I choose to call Jesus, and to my husband, Eddie, whose loving presence gave me courage and strength.

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ABSTRACT

USE OF GUIDED IMAGERY IN CHRISTIAN PSYCHOTHERAPY

IN TREATING MINOR DEPRESSION IN ADULTS

MAY, 1990

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This study examines the affect of guided imagery (GI) in Christian psychotherapy in reducing depression as measured by the Beck Depression Inventory (BDI). The sample for this study consisted of eighteen depressed adult subjects who volunteered to be part of this study. Each subject was randomly assigned to one of two conditions: Non-delayed treatment or delayed treatment. The researcher, a trained Christian psychotherapist, provided weeks of treatment for this study. Treatment effect was measured by the BDI, a self-report rating scale developed for this study, and the Myers-Briggs Type Indicator (MBTI). An ABA single-subject design was utilized. Student's T with a one-tailed test was used to test statistical significance. Statistical significance was found at 0.001 level between pre-treatment and post-treatment BDI scores. Summary and suggestions for further research are presented.

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CHAPTER I

INTRODUCTION

The purpose of this study was to investigate the use of Guided Imagery (GI) in Christian psychotherapy in reducing depression among adult clients. Guided imagery (GI) has been used effectively in a number of areas for a variety of reasons. In career counseling, Skovholt & Hoenninger (1977) report that the "use of guided fantasy enables career counseling to move to a more meaningful level, because the significant material in the fantasy experience comes from the client" (p.694). Kelly (1972) viewed GI as helpful to encourage expression of freely associated material, bypass resistance, encourage primary communications, and develop deeper levels of insights into career choices. Helen Durio (1974) recognized the importance of imagery in creative functioning and suggested that imagery training could be used to promote "productive problem-solving, such as visualizing hypotheses and solutions" (p.243). Ludmila Hoffman (1983) suggested that by using imagery to restructure the context of past and present experiences, partners can gain insights and reduce dysfunctional, defensive postures that prevent a meaningful relationship.

Guided imagery allows the therapist to circumvent the secondary process (such defenses as denial, isolation and repression), (Hammer, 1975) while providing access to the primary processes. This entire process which includes the relaxation techniques would also reduce the external stimuli and cues that keep the person alert to his/her surroundings (Singer, 1974).

Morrison and Cometa (1980), cognitive psychologists, believe imagery to be an effective vehicle for inducing change because of the manner in which most people store experiences, that is, in both verbal and imaginal codes. They suggest that to solely utilize one channel, i.e., the verbal, is to limit the amount of information. Singer (1971) explains that the verbal system is useful for reducing "complexity to simple abstract formulations and accounts for some of man's greatest achievements in science and mathematics, the visual (or other sensory modality) imagery system has the advantages for the recall of complex detail, for the reinstatement of emotion, and for communicating to another some of the same experience felt by the subject" (p.165).

Jung (1960) observed that the advantage of using the imagination was that it bypasses inhibitions which allows much of the unconscious to be revealed. Jung realized three significant functions of active imagination: one,

that it expands the conscious by the addition of the contents of the unconscious. Second, it weakens the dominance and the power of the unconscious and finally, it has a lasting effect, producing pronounced changes in the personality (Jung, 1971).

Guided imagery has been used successfully in systematic desensitization by Wolpe (1982) because he found it difficult to arrange the required graded real-life situation for his particular method. He used imagery situations in place of the real ones. The effectiveness of his research is based on the underlying assumption that "the response to the imagined situation resembles that of the real situation" (Wolpe, 1958, p.139). Lang & et al, (1970) noted several consistent outcomes between physiological reaction to fear imagery and successful therapies which suggest that images by themselves are not "neural events." He found that subjects who were successful had faster heart beats during fear inducing scenes than during scenes that were not as frightening to them. These successful subjects also reported being most fearful at the time their tonic heart beats were also high. Furthermore, those subjects who were most improved showed a systematic lowering of heart rates with repetition of the scenes which in turn was associated with fewer fear signals. These researchers imply that the

"psychophysiological structure of imagined scenes may be a key to the emotional processing which therapy is designed to accomplish" (p.221).

Most researchers have focused on the control issues of imagery (Morrison & White, 1984; White & Ashton, 1977), the cognitive development of imagery (Horowitz, 1968), or the behavioral measures of imagery (Goldfried, 1971). While most of these studies have contributed to a greater understanding of imagery, there has been a lack of studies which focus exclusively on the use of imagery in psychotherapy and its affect on treatment. A few studies such as Morrison's and Becker's (1983) research on the effectiveness of individual imagery psychotherapy compared with didactic self-help seminars on problem behaviors provide some direction. The results of their research demonstrated that both treatments are effective in lowering problem behaviors, however, they found that clients in GI therapy reported significantly lower problems in behaviors than the self-help group.

The effective use of GI may be linked to clients with particular personality traits. Introversion and extra-version as described by the Myers-Briggs Type Indicator (MBI) may be important traits. A study by Huckabee (1974) suggested that imagery-forming ability might be related to

the personality characteristics of introversion-extraversion and neuroticism. The results indicated that introverts obtained higher scores of imagery in evoking of concrete nouns as opposed to abstract nouns. He further found that "ease of imagery was not related to the neuroticism scores, nor was there significant correlation between ease of imagery scores for abstract and for concrete nouns (p.453). A similar research by Gralton, Hayes & Richardson (1979) also suggests that introverts have more imagery and are thus able to be more productive in verbal learning tasks than extraverts. As Huckabee (1974) suggests that "the dimension of introversion-extraversion is a reliable source of moderate variance which should be given attention in design of research" (p.454).

There are many reasons why guided imagery can be a valuable part of psychotherapy. In my professional work, I have used guided imagery to relieve migrane headaches, stress, enable people to reframe negative situations and enable them to develop new behavioral maps. In my Christian psychotherapy work, guided imagery is the primary tool for significant and permanent healing of memories. These successful therapeutic interventions have shown me the importance of using imagery in therapy. It is my belief that the guided imagery techniques and Christian religious factors described in this study could

easily be modified for use by the non-Christian religion therapist.

Guided imagery in Christian psychotherapy has not been reviewed or researched as thoroughly as in other approaches. In fact, this researcher has found only one article in the last twenty years with any significance in this area (Propst, 1980).

Christian psychotherapy as a new emerging paradigm also needs a closer scrutiny especially in its use of imagery as a diagnostic procedure and a therapeutic method (Larzelere, 1980). Therefore, it is the intention of this researcher to examine the relationship of guided imagery in Christian psychotherapy and the relationship to personality types as it relates to depression in clients.

Definition of Terms

Guided Imagery

Guided Imagery (GI) as referred to in this study is the therapeutic method in which a client is guided verbally by a trained therapist to reveal orally an image that expresses unconscious motives without conscious awareness. The client may be taught muscular relaxation in preparation for GI. Verbal instruction by the therapist can be directed in such a manner as to place

the person in a hypnoidal state, that is a slightly altered sense of consciousness. For without this preliminary process, the client would continue to be alert to ego patterns, day-dreams and susceptible to unconscious motives (Kelsey, 1984). Verbal instructions would not only make it easier to access the primary processes, but also, circumvent resistance (since the client is mostly unaware that motives are revealed and provides a beneficial way for the client to free themselves from emotional blocks). The purpose of GI is not only to free the person from the resistance to facing pain, it is also a method that releases from consciousness "elements of conflict, perceptual distortion, self-perceptions and early memories." The primary assumption is that "symbolism inherent in visual imagery constitutes an affective language that can express unconscious motives without causing them to fully impose themselves on conscious recognition" (Sheikh & Jordan, 1981, p.401).

The "altered state of consciousness" as described by Leuner (1969) and other researchers is similar to a state of hypnosis, but somewhat different. The term "hypnoidal" is defined by the Random House Dictionary (1987) as "Characterizing a state that resembles mild hypnosis but that it induced by other than hypnotic means." Barber (1984) suggests that hypnosis and imagining have something

in common. He views the term "hypnosis" as "referring primarily to a situation in which individuals are purposefully guided by carefully chosen words and communications (suggestions) to "let go" of extraneous concerns and to feel-remember-think-imagine-experience ideas or events that they are rarely asked to experience" (p.69). Singer (1974) has this to say about hypnosis and imagery. In a hypnotic trance state, the instructions and the interpersonal situation are able to reduce significantly the external cues which the person would ordinarily attend to and at the same time, increase the awareness of the inner processes and imagery abilities. These are selectively chosen in the hypnotic situation. Whereas in imagery, the "hypnotic aspects have not been emphasized; rather, attention to the free unrolling of imagery is the task demand" (p.216). Singer also comments that the state of at least partial relaxation or the regressive psychological state make the client more aware of "private experiences." All of what does happen (mental images), Singer says, can be a function of the particular therapeutic orientation to which the client is exposed, rather than to hypnosis or some spiritual experience.

Christian Psychotherapy

The definition of Christian psychotherapy theory is based on the assumption of the spiritual nature of man and his need for acceptance of God. Acceptance of God enriches, promotes a sense of wholeness-especially in the psychological areas of guilt, fixations and ego-growth (Vitz, 1985).

Christian psychotherapy combines two types of approaches, each different from each other. The definition of "psycho" is from the Greek word "psyche" meaning spirit, soul and mind and therapy is from the Greek word "theapeia" meaning to cure, to nurse. The term "Christian" refers to a follower of Christ and one who adheres to His teachings (McKechnie, 1979). Paul Vitz (1984) states that the purpose is not to replace one with the other, but "to integrate and connect the two at those places where they meet, namely, at the boundary of psychological and spiritual experience" (p.5).

Christian therapy might also be referred to as "healing" therapy. Inner healing, sometimes referred to as the healing of memories, is distinguished from outer healing which is physical healing. However, physical healing can occur as a by-product of inner healing, since most illnesses have a psychosomatic base (Blackburn, 1976). Inner healing forms the essence of what is

Christian psychotherapy. It is here that the skilled clinician joins with a "higher power" to integrate the experiential and the spiritual to bring wholeness.

Christian psychotherapy differs from pastoral counseling in several ways. Pastoral counseling primarily focuses on providing supports to the client and developing a positive self-image (May, 1979). Hiltner (1949) defined it as "the attempt by a pastor to help people help themselves through the process of gaining understanding of their inner conflicts" (p.121). The symbolic connotations of a pastor in the role of counselor mold the context of their work. There is the authority of the pastor to grant divine absolution and forgiveness. Other tools are the use of prayer, scripture, or the sacraments of the institutions of which the person partakes (Tisdale, 1967). All of these are redemptive rather than therapeutic. In Christian psychotherapy, religious beliefs are important, but secondary to spiritual receptiveness, faith and willingness to resolve intrapsychic conflicts and personal problems that prevent spiritual growth.

Depression

Depression in the Random House Dictionary (1987) states that psychiatric depression is "a condition of general emotional dejection and withdrawal, a sadness

greater or more prolonged than warranted by any objective reason." A more indepth definition formulated by Fann & Goshen (1973) states that depression is:

> A psychiatric condition in which there is a great reduction of activity, deep feelings of discouragement, sadness, hopelessness, a marked limitation of outside interests, and anorexia. The patient's communications usually consist of pessimistic predictions of failure, excuses for not making any effort, and a gloomy appraisal of the past with emphasis on failures. The condition varies in degree and quality from mild to psychotic proportions (p.25).

English & English (1958) defines depression as "a state of inaccessibility to stimulation or to a particular kind of stimulation of lowered initiative, of gloomy thoughts" (p.145).

DSM-III, Revised

The DSM-III-R (APA, 1987) diagnostic criteria for major depressive episode was incorporated into the self-report scale for subjects to use three times weekly.

The BDI is also based on these diagnostic criteria which is:

(1) depressed mood (or can be irritable mood in adolescents) most of the day, nearly every day, as indicated either by subjective account or observation by others;

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation by others of apathy most of the time);

(3) significant weight loss or weight gain when not dieting (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (in children, consider failure to expected weight gains);

(4) insomnia or hypersomnia nearly every day;

(5) psychomotor agitation or retardation nearly every day, (observable by others, not merely subjective feelings of restlessness or being slowed down);

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick);

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others);

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (p.222).

The key concepts that will be addressed throughout this study have been described in this chapter. The reasons for using GI are explained and terms that will be used frequently in this study have been defined. As mentioned previously, only one study by Rebecca Propst (1980) focused specifically in the area of imagery and depression. This present study was formulated as a response to the question of whether using imagery in Christian psychotherapy would be effective in reducing depression.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

This section contains a brief overview of the recent theoretical and research studies on guided imagery in the behavioral and cognitive fields that relate closely to this research project. In particular, Wolpe's (1982) work with imagery in reducing anxieties and phobias in clients provide a model for other researchers in their use of simulated imagery in lieu of "real-life situations." Next, Jung's (1959) theories and concepts of the use of the imagination will be discussed especially as it pertains to the development of the archetypal types and the significance of active imagination and how it operates in the unconscious and conscious mind. Jung's theory of individuation is also discussed because of its relevance to Christian psychotherapy. The early works of Desoille (1965) and Leuner (1969) will provide a frame for the use of imagery in psychotherapy. Both clinicians are experts in the area of imagery and a description of their work will give a practical demonstration of the integration of behavioral psychodynamic approaches.

The last section provides a research on the effectiveness of religious vs. non-religious imagery in

reducing depression. This section will also include a description of the Christian psychologist from the perception of the researcher, assumptions and procedures of Christian guided imagery, and actual cases will be presented.

Behavioral and Cognitive Theories

Wolpe (1982), a long time proponent of behavior therapy, suggests that the "central aim of all psychotherapy is to overcome, or at least significantly diminish, consistently recurring behavior patterns that an individual has learned and that are disadvantageous to him" (p.7). Behavior therapy is formally described by Wolpe as the "use of experimentally established principles and paradigms of learning to overcome unadaptive habits" (p.1). These experimentally established principles according to Wolpe stem primarily from work initiated by Pavlov and Watson who were able to observe "lawful relations that lent themselves to the development of hypotheses to account for the acquisition of patterns of unadaptive behavior, and to suggest methods that might be used to eliminate them" (p.4).

Systematic desensitization is one of the many behavioral methods used to treat neurotic anxiety. Anxiety producing behaviors are progressively eliminated

through exposure to a weak stimulus which is increased to a strong stimulus until the inappropriate emotional habit has been overcome (Wolpe, 1982). Initially, stimuli exposure took place "in vivo," however, Wolpe found it difficult to arrange the required graded real-life situation for this particular method, so he began to explore the use of imaginary situations in place of the real ones. Although Wolpe does not use the term "guided imagery" in his presentation, his procedures appear similar to guided imagery in the use of verbal instructions, the realism of the imagery and the relaxed state of the client. Wolpe's procedures consist of six prolonged training sessions in relaxation based on Jacobson's findings (Jacobson, 1950). Wolpe (1982) reports that the autonomic affects (lowered pulse rate and blood pressure) of the relaxed state is antitheses to those characteristic of anxiety. Wolpe quotes research by Wolpe & Fried (1968) which suggest that "not only are the effects of relaxation opposite in kind to these of anxiety, but, if counterposed to anxiety-evoking stimuli, they diminish the anxiety responses that these stimuli are able to evoke" (p.138). Under those conditions, Wolpe (1982) found that he could increase the threatening imaginary stimuli (depending on the severity of the fears and the personality of the client) one by one until the anxiety evoking potential had

lessened. An important consequence of using this method was the transfer of the deconditioned anxiety to the real-life situation (Wolpe, 1982).

Wolpe (1961) did an outcome study using these techniques. He randomly selected thirty-nine patient cases from his personal records. This study was based on outcome of treatment as indicated by a five-point scale ranging from four-plus to zero. A four-point rating meant a complete or almost complete freedom from fear of the relevant type of stimuli "encountered in actuality" (p. 135). A three-point rating meant that the stimuli had lost 80% of its ability to arouse fear within the patient. The results showed that among the sixty-eight anxiety-response habits of the thirty-nine patients; forty-five of the anxiety-response habits were seemingly eliminated (four-plus rating) and seventeen more markedly reduced (three-plus rating). Among the failures, two patients were unable to imagine themselves in the situation; another patient could not adjust to the required scene and expose herself to more disturbing images. One patient had interpersonal reactions which led to erratic responses. Mean number of sessions for fear was 11.2, while the median number of sessions for each average patient was 10.0. Among the sixty-eight cases treated for fear,

fourteen were classified phobias, five were cases of agoraphobia and the others, claustrophobia.

The effectiveness of the above research is based on the underlying assumption that "the response to the imagined situation resembles that of the real situation (Wolpe, 1958, p.139). Lang & et al, (1970) noted several consistent findings between physiological reaction to fear imagery and successful therapies which suggest that images of themselves are not "neural events." Lang et al., (1970) found that subjects who were successful had faster heart beats during fear inducing scenes than during scenes that were not as frightening to them. These successful subjects also reported being most fearful at the time their tonic heart beats were also high. Furthermore, those subjects who were most improved showed a systematic lowering of heart rates with repetition of the scenes which in turn was associated with fewer fear signals. These researchers imply that the "psychophysiological structure of imagined scenes may be a key to the emotional processing which therapy is designed to accomplish."

Morrison and Cometa (1980) state that if psychotherapy is to produce change then imaginal processes are of prime concern "if for no other reason than that verbalization alone can not encode, store or reconstruct the totality of a person's experience" (p.36). Sheikh

(1983) in his definition of imagery states that imagery, if defined conceptually, is usually one of two types of cognitive codes, i.e., verbal code and visual imagery. Clinicians have generally become aware of two separate memory coding systems for both verbal and visual imagery. Paivio's (1971) theory is that images are linked to nouns which are concrete and advantageous for the recall of complex detail, reinstatement of emotions and eliciting experiences felt by the subject. Verbalization, on the other hand, is useful for encoding abstractions and simplifying complex operations such as math and science (Singer, 1971). Paivio states that "concrete terms such as 'house' readily evoke both images and words as associative (meaning) reactions, whereas, abstract words such as 'truth' more readily arouse only verbal associations" (p.85). Richardson (1969) suggests that under certain circumstances depending on the task at hand, concrete nouns stored as visual or auditory images can be recollected easier than abstract nouns that have the same or comparable meaning and familiarity. Generally, optimal recollection occurs when both verbal encoding and imagery can be used for storage. Horowitz (1983) in his chapter on representation, states that "images are also found in close relationship to emotional processes in terms of memory recollection. In the course of

psychoanalytic psychotherapy, for example, painful and repressed memories and impulses may enter awareness first as images-either in fantasy, free association or dream-and only later labeled in words" (p.73).

Horowitz (1983) suggests that image is formed by dual input, i.e., the image forming systems meld perceptual and memory inputs. He describes four or perhaps five sources of how information enters the visual system. One source is perception. He states that "perception includes the reception of external visual signals, as well as stimuli that arise within the body such as floaters in the antomic eye itself or excitations of the optic pathways (entopic images)". A second source, Horowitz states, includes "the schemata necessary in the construction of perceptual images and storehouse of longterm memory." This store-house has "the recollection of events, recall of fantasy, and reconstructions using various fragments of memory." The third source is "codings retained from prior episodes, episodes retained in a kind of short-term or active memory with a property of recurrent representation." An example of this would be a traumatic episode stored in memory such as can be observed in some post-traumatic stress clients. The fourth source he describes as "a translation from thought cycles occurring in image forming system." The fifth source which he calls "hypothetical" is a parallel

image forming system. He states that this is a "type of image formation into an image system that has been regulated by a secondary process" (p.117). He further explains that "defensive aims can be accomplished through the regulation of each of these forms of input" (p.118).

Use of Guided Imagery in Psychotherapy

C. G. Jung

The early rejection of the hypnagoic imagery (a state similar to before one falls asleep) by Freud (1963) in favor of the technique of free association influenced negatively the course of imagery in academic and clinical psychology investigation, at least in the United States (Hoffman, 1977). Another major reason advanced by Reyher (1963) was Freud's need to disassociate the psychoanalytical method from the earlier hypnotic procedures. Panagiotou & Sheikh (1977) reported that "after Freud in 1955 had begun to be dissatisfied with hypnosis and before he had fully developed free association, he used waking images as an uncovering procedure" (p.170). They further explained, that the images he used were mostly in the visual modality, although they did not discount that other sensory modes could have been used. According to them, it was soon after the development of free association that

Freud began to consider images as another form of resistance. However, European clinicians had no such compulsion and continue "to devolve into the detailed exploration of the intrapsychic by the direct use of imagery" (Hoffman, 1977, p.12). Singer (1974) suggests that "the development of imagery techniques in Europe, particularly vigorous after the end of World War II, reflected a persisting and profound sensitivity and involvement with the world of imagination and with internal experience that had always been part of the intellectual atmosphere" (p.67).

Christian psychologists, Kelsey (1984) and Sanford (1977) among others, generally undergirded their work with the theories and concepts developed by Carl G. Jung. Jung was the first to explore psychic phenomena and to recognize the psychotherapeutic value of the functions of the imagination (Cordner, 1968). Carl Gustav Jung was an early disciple of Freud during the earlier years of the psychoanalytical movement. There were many years of correspondence between them and a deep friendship that lasted several years. One of Freud's first works, "The Interpretation of Dreams," had a great influence on Jung leading him to investigate the process of fantasy or imagination as Jung named it (Cordner, 1968). Their friendship ended for several reasons, among them was

Jung's refusal to put as much emphasis on sex, especially in the importance of infantile sexual traumas (Hall & Nordy, 1973).

Soon after he had parted with Freud, Jung went through a period of disorientation and inner uncertainty, and it was during this period of time that he developed what he calls "active imagination." It was Jung's own experience of his inner journey using fantasies and the importance of this for his clients that led to a new attitude. He stopped trying to influence his clients. The result was that clients would spontaneously speak of their fantasies and dreams and Jung would merely ask certain questions, for example, "how do you mean that?". Jung states, "I avoided all theoretical points of view and simply helped the patients to understand the dream-images by themselves, without application of rules and theories" (Jung, 1960, p. 170). Jung was able to make a connection that "image and meaning are idential: and as the first takes shape, so the latter becomes clear. Actually, the pattern needs no interpretation: there are cases where I can let interpretation go as a therapeutic requirement" (Jung, 1960, p.114).

Jung was very aware of his own image-life and used images of steep descent to explore his own unconscious which led to his first encounter with fantasy figures in

what he termed the collective unconscious. He eventually named these archetypal images. His own historical and anthropological research on symbols of primitive and present societies, led him to conclude that archetypal images were the same symbolically for all humankind (Jung, 1960). He commented that the advantage of using the imagination is that it bypasses inhibitions which then bring the unconscious to light. Jung realized three significant activities of active imagination, one, that it expands the conscious by the addition of the contents of the unconscious. Second, it weakens the dominance of the power of the unconscious and finally, it has a lasting effect, producing pronounced changes in the personality (Jung, 1971).

Active imagination behaves very much like dreams. Jung (1959) describes it as "contents...perceived not by a dreaming but by a waking consciousness" (p.190). Active imagination and dreams both have what Jung calls "unconscious regulators." He explains further that "to the extent that archetypes intervene in the shaping of conscious contents by regulating, modifying, and motivating them (dreams), they act like the instincts" (Jung, 1960). Jung also describes dreams as "self-representation of unconscious developments which allows the psyche of the patient to gradually grow." He goes on

to say, "It is therefore very natural to suppose that these factors are connected with the instincts and to inquire whether the typical situational patterns which these collective form-principles apparently represent are not in the end identical with the instrinctual patterns, namely, with patterns of behavior" (p.115). One aspect of the archetypes that Jung became aware of was its "distinctly numinous character" which he said could only be described as "spiritual." One of the reasons is that archetypes frequently present themselves in the form of a "spirit" or a "ghost" in night-time dreams or in fantasies. Jung remarks that this "phenomenon is of the utmost significance for the psychology of religion. He goes on to say "it can be healing or destructive, but never indifferent" (Jung, 1960, p.115).

Jung's most important conceptual development is the theory of individuation. Nordy & Hall (1974) define individuation as the psyche's tendency to develop in the direction of a stable unity. For this to occur, the various parts that make up the psyche must become differentiated and fully developed. Dourley (1981) regarded individuation as "the conscious realization of one's unique psychological reality, including both strengths and limitations. It leads to the experience of the Self as the regulation center of the psyche" (p.115). Jung uses

the term "individuation" "to denote the process by which a person becomes a psychological 'in-dividual,' that is, a separate, indivisible unit or 'whole'" (Jung, 1959, p.275). Cordner (1968) in his review of the technique of active imagination said that the process is, "primarily an aspect of the individuation process, during which these mental functions which have been repressed are recognized by the individual, and in which the creative center of personality, the self, comes into being." Moreover, "without this process the conscious mind tends toward rigidity and narrowness" (p.125). Jung (1959) observed that individuation is the transformation process which loosened the attachment to the unconscious.

Jung's work with psychological types was the result of almost twenty years of clinical observation and experiences with patients and as well as from his own psychological impressions (Hall & Nordy, 1973). The two basic types Jung (1971) termed introverted and extraverted are called attitude types and the four functional types, he defined as: thinking, feeling, sensation, and intuition. The attitude types are as Jung reports characterized by their attitude towards the object. The extravert's attitude is always focused on representations of the objective world. Jung (1971) states, "when the orientation by the object predominates in such a way that

decisions and actions are determined not by subjective views but by objective conditions, we speak of an extraverted attitude. When this is habitual, we speak of an extraverted type" (p.182). The opposite is observed in the introvert who unlike the extravert is not oriented by the object, but by subjective factors. According to Jung (1971) "that the introvert interposes a subjective view between the perception of the object and his own action, which prevents the action from assuming a character that fits the objective situation" (p.229). Usually one attitude predominates throughout a person's life. However, the other attitude is sublimated into the unconscious and occasionally surfaces in inappropriate ways. As for example, when an extraverted person appears moody and withdrawn, we then recognize that the person is being controlled at least temporarily by the "repressed introversion" (Hall & Nordy, 1973). The four functional aspects of thinking, feeling, sensation and intuition are connected to the attitudes and these orientations are described as: "Sensation (i.e., sense perception) tells us that something exists; thinking tells you what it is; feeling tells you whether it is agreeable or not; intuition tells you whence it comes and where it is going" (Jung, 1964, p.61).

R. Desoille

Desoille's (1965) pattern of psychotherapy closely follows the theories of classical conditioning. Using directed daydream (similar to guided imagery) Desoille puts the client in the anxiety-provoking situation which evokes the unpleasant conditional response; however, at the same time he blocks the reinforcement of the conditional reflex by modifying the situation. That is, the anxiety-producing stimili is replaced by another stimili more pleasant. In this manner the lack of reinforcement permits the reflex to be extinguished.

Desoille begins by having the client in a state of muscular relaxation, isolated as much as possible from sound and in semi-darkness with the eyes closed. He then proceeds to give the client a starting image, for example, for a man, he might use a sword or for a woman, a vessel. He then has the client describe the image in detail and if it is an object, to tell where it is located and where the client is in relation to the object. Symbolically, according to Desoille, the sword represents what the male client thinks of himself as a person and provides the therapist with information on what is repressed, and the full range of "habitual emotional reactions" including those feelings which are rarely expressed, but are there nevertheless (p.2).

In his work Desoille discovered a special feature which seems to make direct daydream distinct and effective. That is the use of imaginary movement in space controlled by the therapist. When Desoille asks the client to image an ascent scene, these images seem to express a sense of calm, of serenity and sometimes joy. However, when he asks clients to image a descent scene, an icnreasing number report somber images, some unpleasant and distressing. An example of the latter would be to direct the client to imagine a seashore, where the waters are deep and to ask the client to describe the scene. Then to suggest that the client imagine putting on a diving suit and to slip into the water, descending as deeply as possible. The client is asked to describe what is happening. Desoille is aware that feelings of fear will quickly surface and if he suggests that something threatening is about to happen, a monster, or an octopus or some sort of frightful thing will soon appear. He then encourages the client to subdue the beast or to tame it with the use of some magical instrument. After this, he has the client take the monster for a tour or up onto the beach. The monster might later, metamorphosis into a person who plays an important role in the emotional life of the client. The phenomena of words like descent and ascent, according to Desoille, are linked to the

impressions of daily life. The daily movement of sun which comes up in the morning brings light and warmth as compared to the setting of the sun which brings darkness and depression is possible as a result of fatigue. Descent represents the probing of elements repressed in the unconscious.

Interestingly, Desoille found his explanation for his findings in the works of I.P. Pavlow. He found the terms such as "conditional reflexes" and "dynamic stereotypes" usually applicable to animals take on a broader significance when applied to man. He states that sensory perception applies to both man and animals, and signifies a "first signal system." However, in man there is a second signal system which is composed of words, either spoken, heard or read (p.14). Desoille found that when a dynamic stereotype is established in man in either of the two signals, that an exact response is given in one of the two systems without additional conditioning. In other words, someone trained to give a finger flexion at the sound of a bell will respond the same at the word "bell" without any prior preparation. Also involved in this second system are visual images, or other visual perceptions. He suggests that there is a strict bond between words and images, that the two are inseparable. A single word can evoke more than one image involving the

olfactory, auditory, and motor senses which are also closely linked to the first signal system. Desoille observes that "all the images which can be evoked by a word can also, in their turn, function as signals, thereby supplementing the second, characteristically human, signal system. This fact is extremely important, for in it lies both the explanation of how psychotherapy acts and its justification for its use" (p.15).

H. Leuner

Leuner (1969) first recognized the importance of imagery from Freud's case on Anna O. in the "Studies of Hysteria." Although he continued to be influenced by Freud, he also had this to say of him, "Freud went on to develop his psychoanalytic therapy on lines other than those which the first experiences with hypnogogic states would have indicated" (p.4). Leuner began his studies of imagery in psychotherapy in 1948, publishing his first study in 1954 on a new psychodynamic method he uses for both diagnosis and as a checkup for the progress of therapy (Leuner, 1969). As a trained psychoanalyst, Leuner was able to note that using his approach of "Guided Affective Imagery" (GAI) did not in any way contradict the basic aims of psychodynamic therapy. He also noted that traditional psychoanalysis required at least 160 hours,

his method required less than 40 hours. Leuner reported, "This therapy is able to relieve acute neurotic disturbance in a short time" (p.5). A follow-up study by Leuner indicated that personality changes and relief from symptoms were still effectual after six years. Leuner, however, did say that he had not had any particular effect on psychotics and drug addicts (Singer, 1974).

According to Singer (1974) who reviewed Leuner's work, Leuner's methods are somewhat similar to Desoille's, but is more systemized. Leuner (1977) defined "imagination" to mean "the human capacity for visualizing mental contents which is a spontaneous manifestation of psyche's urge toward self-representation and communication about itself" (p.73). Leuner's method is simple, the client is asked to lie down and is encouraged to relax with all external stimulus minimized. A verbal suggestion is made to image a scene in a meadow. The client is left alone to imagine anything that comes to mind. The therapist then asks the client to tell what is happening and becomes a "companion" to whatever is happening in the imagery. Leuner (1969) points out that "it is essential to understand that when the patient is in this state of induced relaxation, the mind is functioning differently than in situations of alert consciousness" (p.6). Leuner compares this state to that of meditative state because of its

detailed forms and vivid colors which is experienced as a newness. The client is simultaneously experiencing the fantasy world while still aware of the ongoing therapeutic treatment.

Leuner's (1969) general method uses what he calls "different tools" and consists of ten standard imagery themes presented by the therapist which generally evokes specific daydream trips. Some of these will be highly structured, others will be less structured. The highly structured ones are those designed to explore highly specialized areas such as sexuality. An example of the less structured is the "meadow" scene which is presented as a starting point for therapy. He also uses five major techniques for evoking and interpreting fantasy. These include, the Training Method, the Diagnostic Method, the Method of Associated Imagery, the Symbol Dramatic Method and the Psychoanalytic Method.

Leuner found the Training Method particularly useful for those clients who were unable to image freely. The procedure was to have the clients practice visualizing and describing three scenes: the meadow, the mountain and the brook repetitiously until the clients are able to release their imaginations freely. The diagnostic testing procedure is similar to the pictures of the projective test such as the Thematic Apperception Test. Leuner calls

it the Initiated Symbol Projection (ISP) technique, a strictly diagnostic procedure similar to a projective test, however, different from the therapeutic procedure in its goals and the nature of evoked responses. According to Leuner, speed is critical because it prevents the emotional build up and intense feelings in the responses. If it is given slowly, the subject might have time to build up resistances to his or her own imagery. Even when GAI is used therapeutically, the diagnostic aspect is always present anyway. Leuner remarked that "the therapist is continuously 'reading' and interpreting the symbolic contents of the GAI experiences in order to connect them provisionally with known data about the life history and the dynamics of the patient" (p.13).

The third method is the spontaneous procedure of the use of associated imagery. Leuner applies the process of free association in psychoanalytic technique to the patient's imagination who is encouraged to freely and spontaneously develop a series of pictures. Leuner does nothing to structure or guide even if it becomes as painful as an "anxiety dream" (p.14). Leuner also reports that "age regression" which generally occurs in a deep hypnotic state or during long-term analytic treatment can be observed in GAI by extending the time scale of associative imagery. He does this by assisting the

patient to "link the symbolic GAI experiences with both past events and with the here-and-now of this current life situation" (p.15). The "shared feeling-tone" seems to the common element which appears to be the link in those different time periods. An example Leuner gives is of a colleague who offered to be a subject. In imagery the subject relives an encounter he had recently with a former female patient suffering from anorexia nervosa. What impressed the subject was the expression in the girl's eyes who seemed to trust him and was looking at him imploringly. When Leuner asked him when he had encountered a similar expression, the subject remembered that in his youth, his mother had had that expression after her epileptic fits. The subject then recalled that this was the deep motive for becoming a physician.

The fourth method which is perhaps the most important of Leuner's approach includes six therapeutic techniques. These are taken from Singer (1974) and are described briefly:

1. the intropsychic (inner psychic) pacemaker (a method for giving the subject control over the onset of his own fantasies and associated affect);
2. confrontation (a form of systematic desensitization or implosive technique);

3. feeding (a method for helping the patient mollify frightening monsters which appear in his imagery);
4. reconciliation (making friends with hostile symbolic figures by addressing them, by touching, etc.);
5. exhausting and killing (should only be used by experienced therapist);
6. magic fluids (use of imaginary fluids to relieve bodily aches and pains) (p.83).

This type of psychoanalytic method described by Leuner is successful because "it juxtaposes the repressed aspects of the personality that are associated with a regressive mode of ego-functioning with the more mature ego; it promotes their interaction, and in so doing, it encourages a productive integration of primary and secondary processes" (p.20).

The differences between psychoanalysts and behavior therapists according to Beck (1970) is that the behaviorists use induced imagery in systematic desensitization; however, they structure their content first in their specific instruction to their clients. Psychoanalysts tend not to use induced imagery, but when spontaneous fantasies are reported, they concentrate on their defensive components rather than on their content. Leuner

acknowledges that GAI has certain factors that seem to follow that reasoning, he states, that GAI creates the "relaxation of general character defenses (which are effective in waking consciousness) and censorial barriers by the slightly altered state of consciousness (hypnoid)" (Leuner, 1983). The basic difference Leuner found in particular with Wolpe's approach was that desensitization of the anxiety laden events (hierarchy) took place in a full waking consciousness before the client entered the altered state of consciousness and the anxieties are extinguished by progressive confrontation. As Leuner states "the concept of behavior therapy proceeds on the assumption that the neurosis can be equated with its symptoms. Intrapsychic processes and perception have only marginal significance" (p.5).

Guided Imagery in Christian Psychotherapy

There have been many studies done on the efficiency of using guided imagery as part of a therapuetic mode. But, after extensive research, this examiner has found few definitive studies in the area of the use of guided imagery in Christian psychotherapy or religious counseling. The difficulties of doing a verifiable study of the outcome of Christian therapy are numerous, but not insurmountable. Spirituality can not be measured or

subjected to a scientific or empirical research. Man's spirit is qualitative, not quantitative. However, what can be measured is the observed behavior in conjunction with some behavioral change. For as Scanlan (1974) remarked, "a spiritual healing is a healing by which spiritual stimuli accelerates the natural processes" (p.5).

A research by Rebecca Propst (1980) is one of the few studies which examines the therapeutic efficacy of religious imagery technique. Propst focused particularly upon the "similarities of the imagery processes in the charismatic inner healing movement and cognitive therapy movement" (p.113). Propst used a combination of cognitive restructuring and systematic desensitization techniques in the religious guided imagery treatment for moderately depressed students. The religious imagery treatment consisted of visualizing Christ present in a depressive situation. Thirty-three female and eleven male university students were assigned within a matched sample, to either a religious imagery treatment, a non-religious imagery treatment, a non-directive placebo treatment, or a wait-list control group. The results reveal significant drops in the Beck Depression Inventory for all the groups. However, in a simple sampling of relative proportions, only the religious imagery group (at 14%) showed significantly lower numbers of depressed students than either the

waitlist group (60%) or the non-religious imagery group (60%). The non-directive group had 27% still depressed. Propst found that the most outstanding differences were in the group interaction measures with the religious imagery group showing the greatest increase in activity in all of the five measures of group interactions. This study provides direction for researchers in clarifying and identifying issues in Christian psychotherapy. Propst stated that hers was one of the few controlled outcome studies done that examines the religious component of psychotherapy. The increase in group interactions observed in this study relates to the researcher's own experience with clients in Christian psychotherapy who observed improvement in their relationships with significant others.

The use of guided imagery in psychotherapy has been studied far more frequently than the religious in therapy. To examine what makes guided imagery in Christian psychotherapy a working model will possibly require looking at some of the same variables that make other therapies successful. In this case, it is also my opinion that the particular personality make-up of the therapist is very influential in the success of this therapy. What is needed is a clearer model of what Christian psychotherapy is and what makes it as effective as other therapies or

possibly even more effective. The separate outcome components that can be measured in Christian psychotherapy can be: (1) improved relationships, (2) spiritual transformation leading to greater individuation and self-awareness, (3) increased self-esteem, and (4) decrease of neurotic behaviors including phobias, borderline personality characteristics, depression, etc.

The Christian Psychologist

The researcher's definition of a Christian psychologist is that of a trained professional, a professed Christian who helps clients who have the same Christian perspective obtain normal psychological growth and spiritual maturity through the intervention of inner healing, prayers, guided imagery and other psychotherapeutic methods. The Christian psychologist sees the world differently in that the person is seen as not truly themselves until their life has been completed, and that this completion involves spiritual and religious growth. Jung (1933) maintains that "we can not grow psychologically unless we grow religiously and we can not attain our spiritual maturity unless we mature psychologically." Barry (1983), in her review of Tyrrell's Christotherapy II, describes Tyrrell's ideal Christotherapist as "a cognoscente of the human heart. Possessing the knowledge

and skills of the psychotherapist, he is equally proficient as a guide in spiritual matters--assisting growth in spiritual maturity, in contemplative prayer, in the discernment of providential guidance, in dealing with dark night experiences, etc." (p.59). According to Sneck & Bonica (1981), "a healer must recognize his own brokeness, his own neediness for God's power, his own frailty before the mysteries of illness, emotional disorder and societal turmoil" (p.20). He goes on to relate that an effective Christian therapist needs to have a prayer life that is an active and ongoing relationship with God.

Psychologist Timothy Foss (1977) writes about the psychological changes in clients responding positively to nontraditional approaches in counseling. In his article, he claims that programs which have been successful supply a holistic rather than a dualistic approach to growth and development. Although he reports no research, he said that traditional psychologists are not providing treatment with options for clients. In his summary, he points out that "the profession of psychology has never really successfully dealt with man's spiritual nature." He states that "psychologists need to utilize their unique skills to further explore and understand the inter-relationships between one's emotional, physical and spiritual growth and expansion."

Worthington (1986) has this to say about the clinician in religious counseling, "Recently, a new type of religious counseling has emerged. Clinical and counseling psychologists, trained in secular Ph.D. programs or in Ph.D. programs that are approved by the American Psychological Association and that provide the required training have attempted to integrate religious faith and clinical practice" (p.423). A researcher and clinician, Collins (1980) in reflection said, that "for the Christian professional, integration begins in the life of each integrator. In our integration efforts, we must each seek to be knowledgeable in both psychology and theology, sincere in our deliberations, and honest in our presentations of arguments, theories and data" (p.78).

Christian Guided Imagery

Assumptions

1. Christian Psychology is based on the assumption of the spiritual nature of man and his need for acceptance of God. Acceptance of God enriches, promotes a sense of wholeness--especially in the psychological areas of unforgiveness, fixations and ego-growth (Vitz, 1985). The client is a Christian who believes that Jesus Christ is God (the incarnate) and who religiously can be Christian,

that is, Roman Catholic, Protestant or Anglican, Eastern Orthodox, etc. The Christian client also professes to a living, experiential relationship with Jesus Christ. The client's expectation is that treatment will center around the client's belief system and that healing prayers and the use of the gifts of the Holy Spirit will be part of treatment by the therapist. The King James Bible (1985) describes the gifts in this manner:

> "for to one is given the word of wisdom through the Spirit, to another the word of knowledge through the same Spirit, to another faith by the same Spirit, to another gifts of healings by the same Spirit, to another the working of miracles, to another prophecy, to another discerning of spirits, to another different kinds of tongues, to another the interpretation of tongues" (1 Cor. 12:4-10).

The two gifts most used by the Christian therapist are the "word of knowledge" and the "discernment of spirit." The word of knowledge according to Schwarz (1981) is the hearing of a word from the Lord which will reveal something important to the counseling of the client. Sanford (1966) defines it as a "still, small voice that speaks within our deep minds." In reference to a problem she was experiencing, Sanford explains that "the

actual words may not have been His. But the comprehension of the nature of my trouble was brought up by Him out of the unconscious" (p.99). The bible has this to say about discernment, "But solid food belongs to those who are of full age, that is, those who by reason of use have their senses exercised to discern both good and evil" (King James, 1985, Heb. 5:14). This refers to the mature person who has already experienced a spiritual transformation and becomes sensitive to the spiritual problems of others. William James (1961) describes this change as conversion and stated that "to be converted, to be regenerated, to receive grace, to experience religion, to gain assurance, are so many phrases which denote the process, gradual or sudden, by which a self hitherto divided, and consciously wrong, inferior and unhappy, becomes unified and consciously right, superior and happy, by consequence of its firmer hold upon religious realities" (p.160).

2. An assumption is made that the client is capable of imaging. Goleman (1986) reported that only about three percent of people can not get any mental pictures at all. Leuner (1969) suggests that for some types of clients, that is "full-blown" psychotics or addicts, guided imagery would not seem as useful. However, guided imagery seemed successful with clients who are neurotic, psychosomatic or borderline. Jung

(1983) explains that the causes of neuroses are psychic and that their cure is dependent on psychic methods of treatment. Jung was the first to explore the idea that the psyche could be a causal factor in diseases. Leuner used a simple form of imaging, a meadow, to test that the person could image before proceeding with therapy. In Christian therapy, the person is asked if they can image Christ; if the client shows resistance towards imaging Christ, then an assumption can be made for relational healing (Rizzuto, 1979). Rizzuto (1979) noted that early childhood parental images among other images, formed a person's God representation and influenced self-representations and future relationships. The client who is not able to image Christ is asked if he or she can image something else. This can then be a presence, a light or a significant person in the client's life. Imaging can be accomplished in several dimensions, that is, the past, present and the future. Sanford & Sanford (1985) have found in their counseling that "Jesus Christ is not confined to the dimensions of time and space. He can identify with and heal the spirit of a person at any time past, present or future" (p.46).

Goals

Most clients coming for Christian therapy generally express one goal and that is to have a deeper relationship with Christ. Others sense an uneasiness within, and express it as a "block" that seems to prevent them from feeling "whole." Some have expressed the need to overcome the moral and psychological problems that stagnate and prevent them from going into the world to love more fully. Buber (1970) realized the importance of being able to be separated from self (ego) and actualize oneself in the "you" of the other. According to Buber, the subject who focuses on the "my," as in "my manner, my race, my works, my genius" sets himself apart from others. This person knows himself as a subject, but as Buber said, "this subject can appropriate as much as it wants to, it will never gain any substance: it remains like a point, functional, that which experiences, that which sees, nothing more" (p.114). Jung (1933), in his discussion in Modern Man in Search of a Soul, commented on man's loss of the "metaphysical certainties" and "set up in their place the ideals of material security, general welfare and humaneness" (p.204). He was also aware of a strong instinctual drive towards wholeness and expressed it as an inborn quality that provides civilization with its strongest roots (Jung, 1959). Kelsey (1973) , in his

discussion of Jung's statement, said that "one manifestation of this instinctual drive is transference, in which the unity is obtained symbolically as one comes close to another person who carries an essential part of the psyche for him" (p.304). The end result, if this drive is carried to its conclusion is "genuine wholeness" that is almost like a religious experience. Kelsey comments that "man is instinctively religious and that he can not be truly whole in soul, mind, and body until he has come to this experience, or--to use religious terms--until he has been touched by the reality of God" (p.305). Individuation for the Christian is the exploration of the "darkness" or the shadow that generally resides in the unconscious and expresses itself in dreams of reactions emotionally that are sometimes unintentional, unsettling and neurotic in nature. It is in the process of individuation described by Jung that people begin to understand and express themselves as individuals. Jung said, "only a few favored by grace reach individuation" acknowledging the role that religion has in this process.

Procedures of Christian Guided Imagery

1. Prayers are essential for building an atmosphere of peace and trust. Prayers are a means of entering into partnership with the Lord. Prayers are also

a means of accessing the gifts of the Holy Spirit. As the client begins to feel the presence and the sense of God's grace, there is also the building up of trust and a sense of security. "Peace I leave with you, My peace I give to you; not as the word gives do I give to you" (King James, 1985, John 14:27). Because of the loving and peaceful environment created by prayer, and the specialness of the therapist, the client now feels able to disclose feelings, problems and fantasies, and those types of disclosures can be painful, threatening, even embarrassing. Prayers not only prepare the client for healing, but also spiritually help the therapist to become more focused (Sneck & Bonica, 1981). Taking a quote by Sneck & Bonica (1981) to describe the process, we seek "help from God for specific situations through prayer in a professional context... God's power is invited directly into situations of pain, injustice or disorder" (Gatza, 1979, p.3). The qualities most helpful in a healing therapist are a positive regard, respect, empathy, and love for the troubled person. The therapist allows the love of Christ to flow through to the client. That love is both human and divine (Scanlan, 1974).

2. The interview is generally informal and follows the spirit of peace and quietness established during the prayer time. The client is asked what are the issues that

need counseling. Specifically, in one case, the woman had a damaged relationship with her mother. She expressed feeling hurt and emotionally overwhelmed by the current circumstances in her life. This disclosure provided direction for the therapy. All clients are asked to keep a journal of dreams or insights that may occur before their first appointment. It has been the researcher's experience that the client's call for an appointment, signals the beginning of spiritual journey, and of dreams, insights, fantasies that reveal the nature of the repressed traumas that need healing. It is also the beginning of a spiritual sensitivity to the voice of God (Nouwen, 1966). Following this part of the interview, a family history is undertaken to filter out those issues which seem to be tied to the family line, such as alcoholism, phobias, depression. Surrounding the process of the interview is also the spirit of God which brings about direction and insights. There is usually a catharsis of tears and emotion as what is repressed and hidden is brought to light.

3. The first general diagnosis establishes the criteria for the direction of therapy. One needs to know the broad and general diagnosis whether it is a personality disorder to a type of neurosis. The Christian therapist, through the spirit of discernment, determines

whether the base of the problem is of a spiritual or a psychological nature; it is usually not one or the other, but a mixture of the two. However, the psychologist should be aware that some people are oppressed by darker forces that seem out of the normal range of what is generally observed in clients. Kelsey (1984) refers to this question by asking whether archetypes are personal or transpersonal and concludes that they can be both. He states that there is a principle of darkness that seeks to undermine and bring him to evil. Peck (1979), in his book on the People of the Lie, defines evil, "as a force, residing either inside or outside of human beings, that seeks to kill life of liveliness. And goodness is its opposite. Goodness is that which promotes life and liveliness" (p.86). As for all clinicians, but especially for the Christian therapist, according to Kelsey (1973), the therapist "must also know experientially his own personal and collective darkness, so that he is not overwhelmed by the inner agony which has created the patient's neurotic problems" (p.300). Kelsey (1984) cautions the therapist to be aware that a weak ego structure may be prone to possession in which archetypal powers may take over at anytime. He suggests that personality structure be strengthened so that the person has the powers through God to resist. Sometimes, what is seen as demonic may be, in

fact, "psychosomatic illness, anxiety neurosis with hyperventilation and hysterical and compulsive symptoms, or borderline psychosis" (p.137). The ego has to have a reality base for this deeper walk into spirituality. The client can call upon Jesus "to be strengthened through His might in the inner man" (King James, 1985, Eph. 3:16).

4. In this researcher's clinical experience, the client reacts best to this type of therapy under the following conditions. The physical environment should be quiet and relaxing. The interview usually takes place in one area; however, when it is time for the inner healing and guided imagery, there is a change to a more comfortable and enabling situation with less distractions. Generally, the client is sitting up, facing the therapist at an angle. Touch is an important part of the imagery, especially if it becomes a painful experience for the client. Both females and males are touched lightly on the forearm usually during the guided imagery part of the therapy. This is the entering into the experiential, but staying empathic and separate, process spoken of earlier. Touching was an early part of Freud's technique of stimulating imagery (Singer, 1974). The client's eyes remain closed during the duration of the guided imagery. The therapist asks the client to go through a series of relaxation techniques, although, in not extensive a manner

as Wolpe's methods. The therapist controls the session by use of a soft, modulated tone of voice; the touch affirms and also, lets the therapist know of subtle changes (emotional or psychological) in the client. Without this preliminary process, of relaxation and voice instructions, the client would continue to be alert to ego patterns and day-dreams (Kelsey, 1984). It also makes it easier to access the primary processes, since resistance is lessened as well.

5. Imagery has a major role in the inner healing taking place within the charismatic movement. Charismatic is defined as "in Christian theology, a divinely inspired gift, grace or talent, as to prophesying, healing, etc." (McKechnie, 1979). "Inner Healing," referred to also as the healing of memories is different from physical healing which will sometimes occur as a by-product of the inner healing process. Ruth Carter Stapleton (1976) defines the process of healing as "the experience in which the Holy Spirit restores health to the deepest areas of our lives by dealing with the root cause of our hurts and pain" (p.12). Michael Scanlan (1974) suggests that healing takes place in the "inner man" and explains the inner person as "the intellectual, volitional and affective areas commonly referred to as mind, will and heart, but including such other areas related to the emotions,

psyche, soul and spirit" (p.9). Scanlan (1974) felt that that "healing" was different from a growth process or a qualitative improvement. He viewed healing as that which is wounded or sick, becomes whole and healthy. This researcher found that the process of inner healing closely parallels the process of individuation. According to Kelsey (1984) the first step is to confront one's own faults and in abreaction, in a process similar to confession, share that with another person. This begins the second step which is to love someone. This is the process of transference and it is in this manner that one begins the process of love and developing relationships. The third step, he calls integration. He refers to it as "knowing the outer world and the people in it along with the inner depths, and trying to function as a unity inspired by love" (p.92). He considers this step the hardest, because it involves a great deal of introspection and education. It is at this point that most people seek inner healing as they encounter the resistance within. Linn, et al. (1988) suggested that if "God has built into us patterns of emotional development, stages which we go through in developing as healthy, mature persons. Hurts can interrupt this process and cause us to remain stuck in development" (p.13).

6. The use of guided imagery in healing varies according to the situation. Age-repression imagery, memory healing and event healing may be all part of a therapy session depending on what is revealed during the interview situation. If it is a childhood memory buried deep within the unconscious, the client is then asked to remember anything about a particular event; it may, for example, be a color of the room, clothing, smells, etc. At this point, as the client goes back into the past in imagery, the hand the therapist is holding might feel like a child's hand or it may be that the expression on the client's face starts to soften and become childlike. If the client remembers a room, there always seems to be a reason for remembering these places. One client in particular visualized a kitchen, but didn't know why. As the therapist pressed for details of the kitchen, he visualized more of the kitchen including at this time, his parents. He then remembers why he was in the kitchen, As a small child whenever he did anything wrong, he was spanked by his father in the kitchen, buttocks exposed and his mother sitting, watching. His defenses were so well organized that until this image was brought up, he was totally unaware of the repressed emotions that had become inaccessible to him. The client's referring problem was his inability to handle the complexities of his work and

problems dealing with authority figures. Erikson's (1963) developmental work would suggest that this client is stuck at stage of inferiority vs. industry. Hurts at this stage bring about feelings of incompetency and poor self-image. This client was able to acknowledge the shame and embarrassment he experienced when this was happening. Using guided imagery, he was asked to visualize Christ healing the incident. At this point, the client is encouraged to allow free and spontaneous development of the imagery (Leuner, 1969).

The images used in guided imagery can be multimodal, that is involving smells, tastes, sounds and touch. Images can involve several senses, so that in healing therapy, one needs to be aware of the different senses involved in critical traumas such as rapes, beatings, etc. (Goleman, 1986). Healings may occur in the physical visualization, while the hearing and smell of the trauma may remain locked in the unconscious.

Leuner (1977) noted that when changes in a "fixed" image occurred, the something had changed in the emotional conflict that had significant importance to the client. One example from the researcher's own counseling was when a client described feeling hurt, she located the feeling in the center of her chest and further described this as a heart, but red and exploding with spikes surrounding it.

When asked if there was some way of changing the image, she imaged Jesus holding her heart. When asked if there had been a change, she added that the heart looked normal, the hurt feeling seemed to be gone and the spikes had disappeared. Leuner (1969) named this a "phenomenon of change." He seems to suggest a corresponding correlation between image and emotion. David Grove (1987) has demonstrated a similar concept in his seminars "Resolving Traumatic Memories." There are four ways that the client knows that a memory has been restructured: "(1) The client will know on an affective, visual, cognitive and behavioral level. (2) The client will remember the memory differently, feel differently about it, see it differently and still have a 'knowing' about what originally happened. (3) The affect attendant to the memory will have a neutral or positive valence. (4) Because the affect is change in the past, it also changes the present or future allowing the client to overcome his/her limitation without the physiology of effort" (p.26).

CHAPTER III

METHOD

Research Design

This study examines the effect of guided imagery (GI) in Christian psychotherapy in reducing depression as measured by the Beck Depression-Inventory (BDI). In addition, the researcher sought to identify personality characteristics of the subjects that might interact with treatment effect. Personality variables were measured by the Myers-Briggs Type Indicator (MBTI). Single-subject design (ABA) was utilized to provide data for individuals over time and conditions. Behavioral variables taken from the DSM-III Revised form the basis for the self-report scale used to measure changes in feelings of depression (Sulzer-Azaroff & Mayer, 1977). The behavioral variables used in the self-report scale are related to minor or major behavioral indicators of depression such as depressed mood, weight loss, or gain, insomnia, fatigue, feelings of worthlessness or inappropriate guilt, etc. These depressive behaviors were assessed three times a week by the subject. The ratings determined the initial baseline readings. Variables such as sex, age, occupation and education were also studied in order to measure any relationship with treatment affect.

Research Questions

The research questions formulated were:

1. Will levels of depression measured by the BDI before and after experiencing the sessions of GI change beyond what might be expected by chance?
2. What personality variables as measured by the MBTI will correlate with differences in changes on BDI before and after experiencing GI?
3. Will self-reports completed three times per week during the weeks of treatment and one month after treatment show changes in emotional state (depression) and daily living activities?
4. What part of the treatment of the sessions will the subject see as positive and what part as negative?

Procedures

Sampling

Eighteen adult subjects, six males and twelve females, ages eighteen to sixty were solicited from the general pool of referrals received by the researcher as well as from advertising in the local paper (Appendix A). Subjects were informed of the Christian focus of the

psychotherapy. Each subject was asked to volunteer for this experiment consisting of a pre-testing sessions before and post-testing sessions after the treatment. Every other subject was randomly assigned to a delayed treatment program (except for two subjects who were in crises). This did not include the first ninety minute evaluation session. Subjects were asked to make a commitment to sixty minute counseling sessions. Subjects who were unable to make the scheduled appointments were asked to continue their self-evaluation forms until their next session. Subjects who were suffering from a more serious pathological problem based on the result of the BDI and the DSM-III diagnostic scale for depression were excluded and referred to an appropriate agency, except for one whose diagnosis of manic depressive disorder was not immediately confirmed. Those who scored in the mild, moderate and severe range of depression on the BDI and who were not currently suicidal were included in the study. One subject who had to leave on an unplanned trip was given an accelerated program of twice weekly treatment. Subjects were asked to fill out an evaluation form at the end of treatment (Appendix B). The researcher, a doctoral student in counseling psychology with ten years of clinical experience, under the supervision of a licensed psychologist, administered the guided imagery treatment

and collected all the data. Table 1 (See p.61) presents the schedule of treatment and the management of the three phases of treatment.

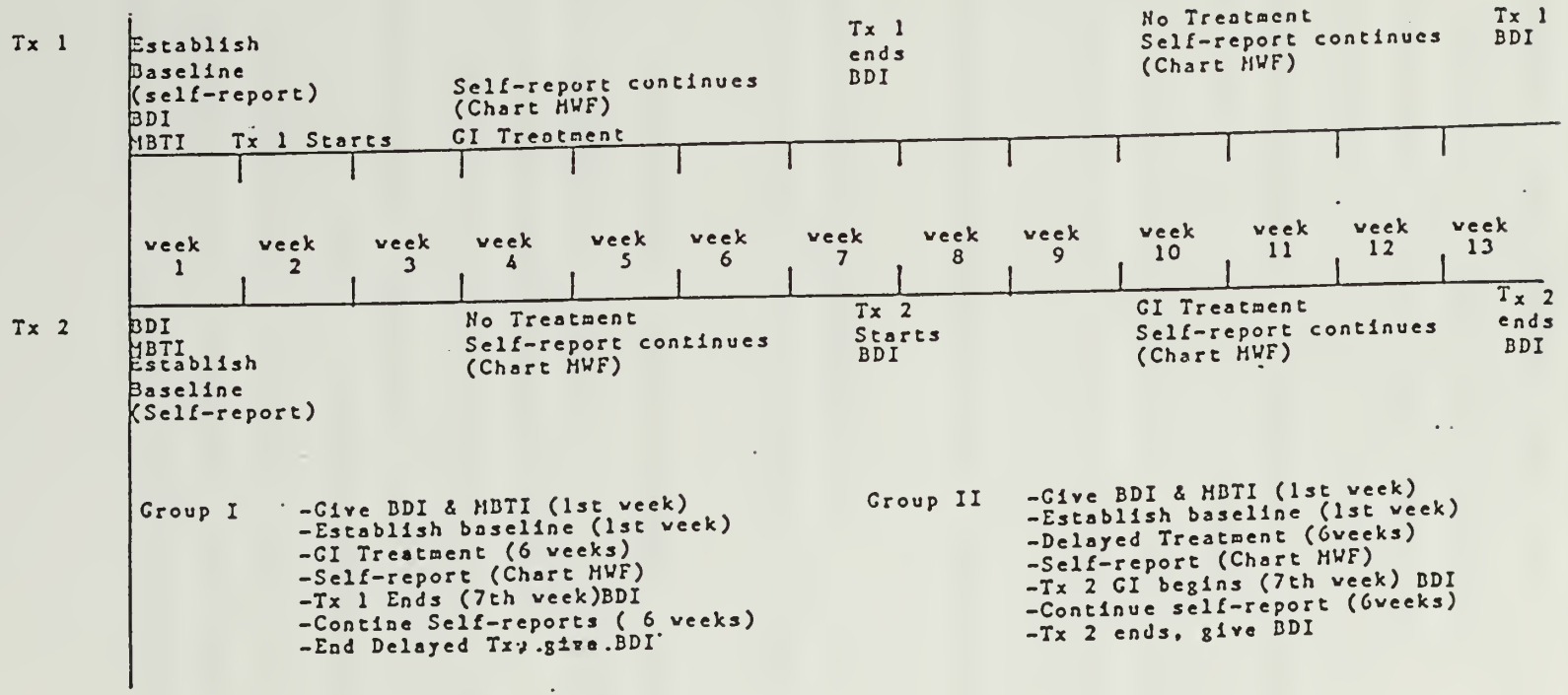
Treatment Procedures

An assumption was made that for this treatment the subject be a Christian who professed to have a living, experiential relationship with Jesus Christ and was aware that treatment would involve prayers and guided imagery of a religious nature. Prayers were utilized to build an atmosphere of peace and trust. It was anticipated that the subjects would be more willing to disclose feelings, problems and fantasies and even those kinds of disclosures that were painful, threatening and embarrassing in a relaxed atmosphere of trust. Religious music was played in the background during the guided imagery sessions and was a part of treatment (List of music titles appear in Appendix C). The physical environment was quiet, with few outside distractions. During the sessions, the subject was sitting up, facing the therapist at an angle (For diagram of room, see Appendix D).

The use of guided imagery varied with the content that was expressed by each individual subject (See below). Age-regression imagery, memory healing and event healing were all part of a therapy session depending on what was

Table 1

Treatment Schedule



Group I
- -Give BDI & MBTI (1st week)
- -Establish baseline (1st week)
- -GI Treatment (6 weeks)
- -Self-report (Chart MWF)
- -Tx 1 Ends (7th week)BDI
- -Contine Self-reports (6 weeks)
- -End Delayed Tx; give BDI

Group II
- -Give BDI & MBTI (1st week)
- -Establish baseline (1st week)
- -Delayed Treatment (6weeks)
- -Self-report (Chart MWF)
- -Tx 2 GI begins (7th week) BDI
- -Continue self-report (6weeks)
- -Tx 2 ends, give BDI

revealed during the initial diagnostic interview. The initial interview was a ninety minute session used to explain the contract, the treatment plan and the evaluation process. During this time the pre-tests were administered and counseling goals were identified.

Before the guided imagery, the researcher asked the subject to undergo a series of three minute relaxation exercises which consisted of the subject breathing deeply three times and relaxing the upper torso. The researcher used a soft, modulated tone of voice with the relaxation techniques (music and muscular exercises) to put the person at ease and permit access to the primary processes.

Specific Procedure for Guided Imagery

Each session was about sixty minutes in length.

Session 1. (Evaluation; ninety minutes.) Therapist greeted subject and began the interview and evaluation process to assess present psychological status. Information gathering included the history of subject, siblings, present marital status, past hospitalizations, past therapeutic interventions, etc. (See history form in Appendix E). The experimental procedure was explained, that is, the sending of the self-reports, the length of the intervention, what the therapy entailed, discussion on

any questions the subject might have had and the signing of a contractual agreement for treatment (See Appendix F). Pre-tests of the BDI and self-report were given. The MBTI was also administered.

The following statement was repeated to each subject:

"This experimental treatment will consist of therapy sessions, each sixty minutes long. There will be two parts to each therapy session. The first part will consist of discussion of your particular problem, the next part will be the use of guided imagery and prayers to help solve that particular problem. You will be asked to fill out a self-report three times weekly, Monday, Wednesday and Friday and mailed out to me for the sixteen weeks of treatment and during the non-treatment time. It is very important and essential to this research that the reports are filled out on those days at the same time. I am now going to give you the first test which will take approximately fifteen minutes and then I will give you another test which will take approximately thirty-five minutes to complete. When these are done we will do the evaluation which includes a medical history, a history of your family and the reason for therapy and any goals you'd like to accomplish during this treatment time. Do you have any questions?"

Session 2. The therapist started the session by asking the subject how the week went, that is, how he or she felt in retrospect to treatment that was about to begin. The next part of session two was spent discussing some of the issues that were brought out in the history-taking. An intervention was developed based on this sharing. In this second session, the evaluative interview was concluded. I started by saying: "Good morning, before we start I'd like to know how you are feeling this week?" or "How did your week go?" "Do you have any difficulties with doing this session or any questions concerning the program?" The subject was asked to sit in chairs that have been especially arranged with the subject facing the therapist. The room lights are dimmed and soft music is turned on. For each session, the same prayers are said. "We turn to the Father in Heaven who is our Abba father and ask that He be present as the creator to re-create and bring about new circumstances. He also gave us the son, Jesus who became man for our sakes and in obedience to the Father walked on earth. He was aware of what it was like to be human, to suffer, to experience betrayal, rejection, loss and all that we experience, and finally death. For our sakes he stood quietly as he was beaten, tortured, knowing the Father's will for Him, permitted Himself to be crucified. His death brought us

life, and the reconciliation of the Father and most importantly it brought us forgiveness for all times, for our sins always. He gave us another gift and that is the gift of the Holy Spirit. And, we invite the Holy Spirit to be present as we minister to you and we empty ourself of all self so that the Holy Spirit can work through us in all the gifts of the Holy Spirit. We ask that the Holy Spirit release in us the anointing of the gifts that is work of knowledge, discernment of spirits, wisdom and truth. He said in His word that we are children of light and we ask that all truth be revealed. We ask the protection of the Lord Jesus Christ over this room, over all our children, over our properties, over our cars and our animals."

The therapist began the relaxation exercises in preparation for the imagery process. The relaxation exercise was standard for each imagery therapy. "I want you to close your eyes, now take a deep breath, that's it, now let it out slowly. Now do it again, remember to let it out slowly. Now remember, don't open your eyes. Now, take another deep breath. Now, I want you to feel the neck muscles and if there is any tension there, I want you to relax them. Now, feel your shoulders and do the same thing. Put your hands out, open. Relax them. Feel your back, and if there's any tension there, try to let it go.

Do the same now for your hip and your legs. You will experience a lightness, a sensation of floating, stay in this now."

Imagery Process

Imaging was done in several different ways depending on the healing to be done. For example, if there was a clear issue or childhood trauma such as a beating, the the imaging would go thus: "I want you to image that incident where you were so scared. What were you feeling? Tell me where you were and what was happening. Can you image Christ? (If subject can not image Jesus, they are asked to image a valued person or in some cases, they themselves as adults can be the healer). Now, just let Jesus be the healer." (At this point, I ask them to describe what is happening and they continue the process themselves.) "Stay there for a while."

If the person can only remember just a scene, but doesn't know why, the imaging might be to regress the person to whatever happened: "You remember being in the kitchen, but don't know why? What can you see around you? What color is the wall? Where is the sink? Now, who is there with you? What is happening with your parents? Where is you mother standing? What are you feeling that is happening?" (In this particular case the subject

remembers being in the kitchen, but didn't know why. The researcher pressed for more details of the kitchen, this time the subject visualized the colors and the kitchen table and saw his parents. He then remembered why he was in the kitchen. The incident was the act of being spanked by his father while his mother watched.) "Now, I want you to imagine Jesus coming into the kitchen, tell me what is happening? Is Jesus speaking to your parents, what is He saying? Stay in that peace for a while." The therapist and subject process what has happened and ending prayers were said that are specific to what occurred beforehand.

Session 3. This session was focused on particular issues that the subject had brought to therapy. These included recent painful events and relational problems that might have surfaced as the result of the therapy process and become a part of the imagery treatment. At this point there was more understanding of what imagery is and how the subject was utilizing it without the intervention of the therapist. As in all the sessions, dreams, visions and insights as well as healings were shared, and interpreted for the subject. The rest of the sessions continued the process outlined previously with the variations described using the imagery process.

One variation was the use of biblical stories to place the person in a situation of releasing and healing a relationship. In this case it was usually a very enmeshed relationship where the subject was always in a state of flux, worried and overinvolved with a person, usually another family member. The imagery used was of Abraham taking his son Isaac to be sacrificed on the mountain top (Gen 22:1-12). This is how it proceeded: The passage was read from the Bible and then the researcher said, "I want you to image your family member, good, now you are both walking up to the stone altar on the mountain. I know how difficult this is for you, are you ready? Now place that person on the altar and give that person up to God just as Abraham did with Isaac. (Time of reflection and silence, usually subjects are crying as they release their beloved.) Prayers were said that include the Blessings given Abraham for his obedience to God. At the end of all imagery there was discussion concerning the experience. The subject was encouraged to share the feelings and emotions that occurred during the imagery.

Session 4. The subject was encouraged to bring up issues that need healing and twenty minutes before the end of each session, imagery was initiated. Unresolved issues with a beloved one who has died might be addressed in a

role-playing imagery situation. In this situation, a chair was placed in front of the subject and the session proceeded as follows: "Now image you father, tell me what he looks like and what he is wearing. Now finish the sentences, Dad, I've always felt..., you have never..., I want you to know... Now, listen to his reply, what does he say to you?" The subject will often experience a wide range of emotions, that is, anger, rage, despair, hate and love sometimes coexist. This type of dialogue continued for a while and then the therapist asked the subject a final question: "Can you say Goodbye now, are you ready to let go?" At this time the subject usually undergoes grieving. Once this process is over, the subject was asked to share and discuss feelings.

Session 5. Occasionally, a subject is unable to pinpoint a painful event, yet has an inner pain or anxiety without a reason or a cause. In cases like this, a technique developed by David Grove (1989) is useful. The subject is asked to image the painful event and to locate it. The subject might say that it is in the heart. Questions would be the following: "And, if it is in the heart, what does that look like?" The subject would answer. "If it is red and exploding and has spikes surrounding it, what else can you tell me about it?" The

subject answers. And the questions continue in this manner, "Now what happens, or take some time to think of the heart and tell more" and ends with, "and what can you do to change this?" The subject might image God holding the heart. In one case, when asked what was happening, the subject said, "Jesus is holding my heart, the heart looks normal and the hurt feeling is gone." The subject felt empowered doing this type of imagery and in the processing might express this sense of being in control by saying, "it's over" or "it's finished."

Session 6. This session was the final session. Subjects were re-administered the BDI and they turned in their self-reports from that week. The subjects were asked to evaluate the sessions using the informal questionnaire developed for this purpose. If they were going into the delayed stage, they were asked to continue the three day self-reporting. It was explained to all the subjects that they had the option of continuing therapy after the delayed period, if they felt the need for continued treatment. Subjects who were still seriously depressed were checked by phone and support systems were set up, i.e., prayer groups and Adult Children of Alcoholics (ACOA) groups are an example of some of these provisions.

Instrumentation

Beck Depression Inventory

The Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Morck and Erbaugh, 1961) was designed to measure the behavioral aspects of depression. The BDI (self-reporting) instrument used for this study has been revised in 1972 since its development in 1961. This instrument includes most of the original 21 scale items which are: (1) mood; (2) pessimism; (3) sense of failure; (4) self-dissatisfaction; (5) guilt; (6) punishment; (7) self-dislike; (8) self-accusations; (9) suicidal ideas; (10) crying; (11) irritability; (12) social withdrawal; (13) indecisiveness; (14) body image; (15) work difficulty; (16) insomnia; (17) fatigability; (18) loss of appetite; (19) weight loss; (20) somatic preoccupation; and (21) loss of libido (Beck & Steer, 1987). Although the BDI was designed to assess the severity of depression in psychiatrically diagnosed patients, its use has extended to evaluating depressive syndromes in normal adolescent and adult subjects (Steer et al., 1986). Caution has been suggested in using the BDI because of its difficulty in separating those individuals in a state of sadness from those clinically depressed (Hesselbrock et al., 1983).

In comparison with the DSM-III Affective Disorder criteria, Morgan and Lambert (1983) found that the BDI represents six out of the nine DSM-III criteria well. For example, the BDI asks about weight loss, but not weight gain and similarly, it asks about sleep difficulty, but not if the person has been sleeping more than normal. Agitation and psychomotor activity were completely excluded. Beck (1967) excluded these intentionally. Agitation, a clinically diagnosed symptom, was excluded because it was considered inappropriate for a self-report instrument. Increased appetite and sleep were excluded because they were found to occur so frequently in normal adults, and including them might produce a "high rate of false positives" (p.34). Data from six normative samples employed by the Center for Cognitive Therapy (where research originated) to investigate the reliability and validity of the revised BDI showed that the BDI had a high internal consistency in both clinical and nonclinical populations (Beck, 1987). Beck states that internal consistency estimates are based on Cronbach's coefficient alpha for the mixed, single-episode major depression, recurrent-episode major depression, dysthymic, alcoholic, and heroin-addicted patients were .86, .80, .79, .90, and .88, respectively. The original research (Beck, et al.,

1961) on reliability was established using four psychiatrists as raters. Two psychiatrists saw 100 cases and agreed in 75% of the cases regarding the major diagnostic disorders of psychotic disorder, psychoneurotic disorder and personality disorder. There was a higher agreement among the psychiatrists on the "Depth of Depression" which measures the intensity of depression. On a four point scale, agreement was 97% of the cases. Beck and associates (1961) used the protocols of 200 cases to establish the internal consistency of the Depression Inventory. Using the Kruskal Wallis Non-Parametric Analysis of Variance by Ranks, they found that all categories had a significant relationship beyond the 0.001 level. A split-half evaluation composed of 97 cases yielded a coefficient of 0.86 using the Pearson r and 0.93 using the Spearman-Brown computations.

The validation of the Depression Inventory was established using the Mann-Whitney U test to measure the differences between the scores on the Depression Inventory and the Depth of Depression ratings. The differences between all categories (none, mild, moderate and severe depression) was significant at <0.0004> for both these studies.

Myers-Briggs Type Indicator

The Myers-Briggs Type Indicator, (MBTI), (Form G, 1985), is a self-report inventory based on Jung's theory of psychological types and measures four bipolar types that is extraversion(E)-introversion(I), judgment(J)-perception(P) and the four functions; sensing(S)-intuition(N), thinking(T)-feeling(F). The EI measures whether a person is an extravert or an introvert. Extraverts seem to be more oriented to the outer world, their judgment and perceptions are based on people and things. On the other hand, the introverts are more inner focused and tend to have their perception and judgment shaped by concepts and ideas. The Sensing/Intuition (SN) index reflects a person's perception between two different ways of perceiving, the sensing (S) which gives the person "observable facts" through one or more of the five senses and (N) which relies more on the intuitive providing information on meanings, relationships and other possibilities that seem beyond the range of the conscious mind. The Thinking/Feeling (TF) index obtains a measure of a person's preference between two contrasting types of judgment. A person may rely on thinking and decide objectively on logical consequences, or on the feelings which a particular social situation engenders. The Judgment-Perception (JP) index reports on the process a person uses

primarily in dealing with the outer world, the person using judgment to deal with the outer world will use thinking or feeling, while the person who prefers perception will report a preference for using either (S) or (N) in dealing with the outer world (Meyers & McCaulley, 1985). "Test-retest reliability demonstrated that the MBTI was consistent in measuring what it proposes to measure. Coefficients ranged from .45 (14 months) to .87 (7 weeks)" (Mitchell, 1985).

Each of the representative types are discussed in the manual and career tables are established for the sixteen possible combinations (Meyers & McCaulley, 1985). Estimates for reliability are based on the Spearman-Brown prophecy formula done on samples ranging from .43 to .88 for EI, .34 to .91 for SN, .00 to .88 for TF, and .28 to .92 for JP. Scores below .60 were attributed to the younger, the underachiever or the educational disadvantaged persons.

Validity is established with correlations on at least twenty-eight other psychometric instruments, one of them is the Jungian Type Survey. The twenty-eight instruments are described in detail in the manual. However, some positive correlations were related to variables such as personality measures, SAT performance, selected Strong Vocational Interest Blank scales and the Edwards Personal Preference Schedule.

Self-Report Scale of Depression

The self-report scale composed by the researcher is modified from the DSM-III R diagnostic criteria for depression. According to Hesselbrock, et al (1983), the "DSM-III is a useful guide for making diagnoses and is widely used by researchers and clinicians. To enhance diagnostic reliability, it provides operational diagnostic criteria" (p.400). The self-report scale contains eight out of the nine diagnostic questions that relate to a mood in a particular day. Its primary purpose in this study is to provide a baseline for daily behaviors and also, as a check with the other self-report instrument, the BDI. To develop the scale each of the DSM-III terms were broken down into bi-polar sentences, both positive and negative, and translated into comparative comments used in the common vernacular language. Four non-expert, independent raters were asked to rate these sentences in terms of their meaning and similarity to the DSM-III list (See Appendix G). Subjects established their own norms by doing the self-reports the three scheduled days. The self-reports can be considered idiographic, each case stands as an individual unit, separate from each other.

Data Analysis

Research design follows the ABA single-subject design. The baseline A was established the first week using the self-report form the established three days, i.e., Monday, Wednesday and Friday, before treatment started. A pilot study on one subject suggested that it would be better to have subjects fill out forms three times a week rather than one the seven days as originally planned. Descriptive data from the research were analyzed using charts and graphs and the differences were tested using appropriate statistical procedures. One case was taped and transcribed. Excerpts illustrating GI in Christian psychotherapy are included in Appendix H.

CHAPTER IV

RESULTS

The Sample

The purpose of this study was to investigate the use of Guided Imagery as it is utilized in Christian psychotherapy to reduce depression among adult subjects. Twenty-six subjects (10 males, 16 females) originally volunteered to be part of the study. Eight dropped out or discontinued for various reasons. Among these eight, one male subject had signed up for a program at the local Veterans' Administration hospital. Another male subject was undergoing withdrawal from alcohol addiction and ended up in a county jail for outstanding warrants for DWI. A female subject dropped the program because she felt the travel time was too long to come for treatment. Two were no-shows. Follow-up phone calls resulted in another appointment for one of these subjects who also became a no-show. The first male subject was dropped from the study because he continually failed to show for appointments. However, he was offered therapy and continued this for a while. A female subject who completed the delayed portion of the program did not come in for the intervention even after numerous phone calls and rescheduling of appointments. One female subject who did the study was

dropped because her therapy ended after the deadline for this study. Eighteen subjects completed the study. As much as possible, subjects were assigned randomly to either of two conditions, immediate intervention (non-delayed phase) or delayed intervention. Two subjects were shifted to a non-delayed program because of clinical considerations. One subject could not keep her appointments, and as a result, was placed in the delayed program. The first referral was designated a pilot study. This subject was irresponsible in keeping appointments and was finally dropped. As the result of this first attempt, a decision was made to limit the self-reports to three times a week instead of the daily reporting that was originally scheduled. Subjects unable to keep their appointments continued the self-reports until their next appointments. Referrals came from the general pool of referrals received by the researcher. An advertisement was placed in the local papers seeking volunteer subjects. The study was started in May, 1989 and concluded at the end of March, 1990. Many referrals came during the Christmas season which appears to be a time of stress and when depression is more prevalent. In totality, seven referrals came from churches or religious groups, six referrals came from Alcoholic Anonymous groups, three were from the general pool of applicants received by the researcher, and two

subjects came as a result of the advertisement. Baselines were established on all but three subjects, these being in crisis and in need of immediate treatment. No baseline was established in these particular cases. The delayed subjects were not assigned to a designated baseline because the delayed program precludes a specific time for this intervention.

The ages of the subjects varied greatly. For clarity the ages of the subjects were collapsed into three separate age ranges. The results were 3 subjects in the range of 18-25 years, 10 subjects in the range of 25-45 years and 5 in the range of 45-65 years. The mean age for all subjects was 39.44. The mean for females was 38.33 and the mean for males was 41.66. The number of blue collar workers (11), i.e., those in construction, maintenance or non-professional health care, etc. far exceeded all other groups. Two subjects were in white-collar positions: a sales administrator and an electronic buyer. Five were in professional occupations primarily as educators. One was a writer. Educational backgrounds were mainly high school graduates (8), and one subject had an Ed.D. and another a M.Ed. Two had B.S. degrees; one had a B.A. degree. Three had high school diplomas and one had not completed high school.

Research Questions

Research Question 1

Will levels of depression measured by the BDI before and after experiencing these GI sessions change beyond what might be expected by chance?

The data for this first question are presented in Table 2 and Table 3 (See p.82). The eighteen subjects were administered the BDI on three different occasions. The first BDI was administered to all the subjects on the first day of contact with the researcher. For the non-delayed subjects, the BDI was administered again at the end of the treatment phase and at the end of the follow-up treatment phase. For the delayed subjects, the BDI was administered at the first contact, before treatment and then, again, after treatment. Twelve of the eighteen subjects had lower BDI scores (less depression) at the end of treatment than at the beginning. Of these, case number 14 had a notable change from extremely severe depression on the pre-treatment score to no depression on the end treatment score. The BDI pre-treatment scores and the end treatment scores for all subjects were compared using a t-test (Figure 1, Table 4). (See p.83.)

Table 2

REPORT OF BECK DEPRESSION INVENTORY (BDI) SCORES BY CLIENTS WHO BEGAN TREATMENT FIRST (NON-DELAYED)

N=10

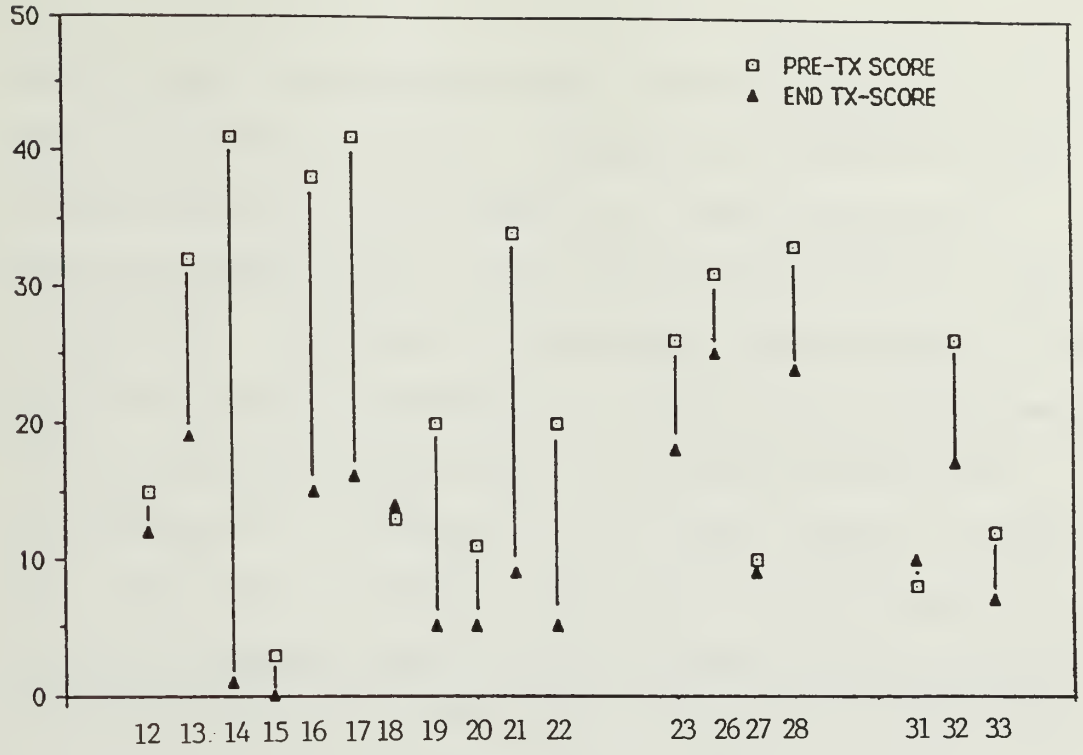
Case #	Pre-Tx Score	End Tx Score	Follow-up Score
#12	(15) mild. mod. dep.	(12) mild mod. dep.	(13) mild mod. dep.
#14	(41) extrem. sev. dep.	(1) no depression	(1)) no depression
#16	(38) extrem. sev. dep.	(15) mild mod. dep.	(19) mod. sev. dep.
#17	(41) extrem. sev. dep.	(16) mild mod. dep.	(14) mod. sev. dep.
#19	(20) mod.sev. dep.	(5) no depression	(6) no depression
#22	(20) mod.sev. dep.	(5) no depression	(6) no depression
#25	(26) mod.sev. dep.	(18) mild mod. dep.	(19) mod. sev. dep.
#26	(31) extrem. sev. dep.	(25) mod. sev. dep.	(8) no depression
#28	(33) extrem. sev. dep.	(24) mod. sev. dep	(33) ext. sev. dep.
#32	(26) mod. sev. dep.	(17) mild mod dep	(12) mild mod. dep.

Table 3

REPORT OF BDI ON CLIENTS WHO WERE IN DELAYED TREATMENT

N=8

Case #	Initial Score	Pre-Tx Score	End Tx. Score
#13	(23) mod. sev. dep.	(32) extrem. sev. dep.	(19) mild sev. dep.
#15	(16) mild mod. dep	(3) no depression	(0) no depression
#18	(29) mod. sev. dep.	(13) mild mod. dep.	(14) mild mod. dep.
#20	(11) mild mod. dep.	(11) mild mod. dep.	(5) no depression
#21	(24) mod. sev. dep.	(34) extrem. sev. dep.	(9) no depression
#27	(19) mod. sev. dep.	(10) mild mod. dep.	(9) no depression
#31	(10) mild mod. dep.	(8) no depression	(10) mild. mod. dep.
#33	(14) mild mod. dep	(12) mild mod. dep.	(7) no depression



Note: Lower BDI score indicates reduced level of depression

Figure 1
Combined Beck Depression Inventory Scores for All Subjects Before and After Treatment

Table 4

Beck Depression Inventory for 18 Subjects Pre-Treatment and End-Treatment Scores

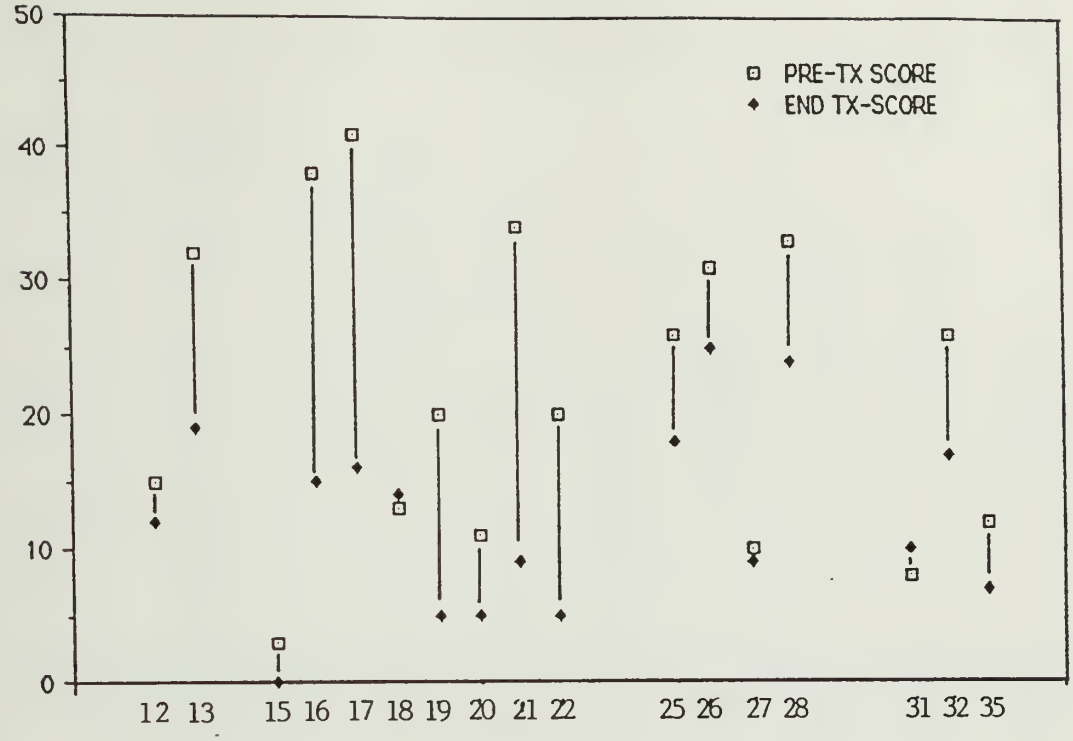
Paired Samples...

Variable:	Pre-Tx Score	End Tx Score
Mean:	23.00	11.72
Std. Deviation:	12.12	7.31
Paired Observations:	18	

t-statistic:	4.35	Hypothesis:
Degrees of Freedom:	17	Ho: $\mu 1 = \mu 2$
Significance:	< 0.001	Ha: $\mu 1 \neq \mu 2$

Overall, the results were highly significant at 4.35 using the 17 df ($P<0.001$ level). Dropping one subject who went from a score of 41 to a score of 1, the results still remained significant at 4.60 using 16 df ($P<0.001$) (Figure 2, Table 5). (See p.85.) Statistical calculations of the results for the 10 subjects in a non-delayed phase between the pre-treatment scores and end-treatment scores was significant at 4.21 using 9 df ($P<0.002$) (Figure 3, Table 6). (See p.86.) However, there was no significance on the end-treatment score and the follow-up score on the BDI (Figure 4, Table 7). (See p.87.) Comparing Table 6 with Table 9 revealed that subjects who had treatment first contribute significantly more to the differences between pre- and post-treatment scores. For the 8 subjects in the delayed program, the results were significant between initial BDI scores and pre-treatment scores (Figure 5, Table 8) (See p.88.), but were insignificant when comparing BDI scores at the time of the delayed (baseline) phase to treatment (Figure 6, Table 9). (See p.89.)

An interesting difference emerged when females were separated from males. Males, according to the BDI scores, did not differ significantly before and after treatment scores (Figure 7, Table 10). (See p.90). The 12 females did improve their level of depression pre- and post-treatment. (Figure 8, Table 11). (See p.91.) Females as



Note: Lower BDI score indicates reduced level of depression

Figure 2
Combined Beck Depression Inventory Scores for 17 Subjects Before and After Treatment

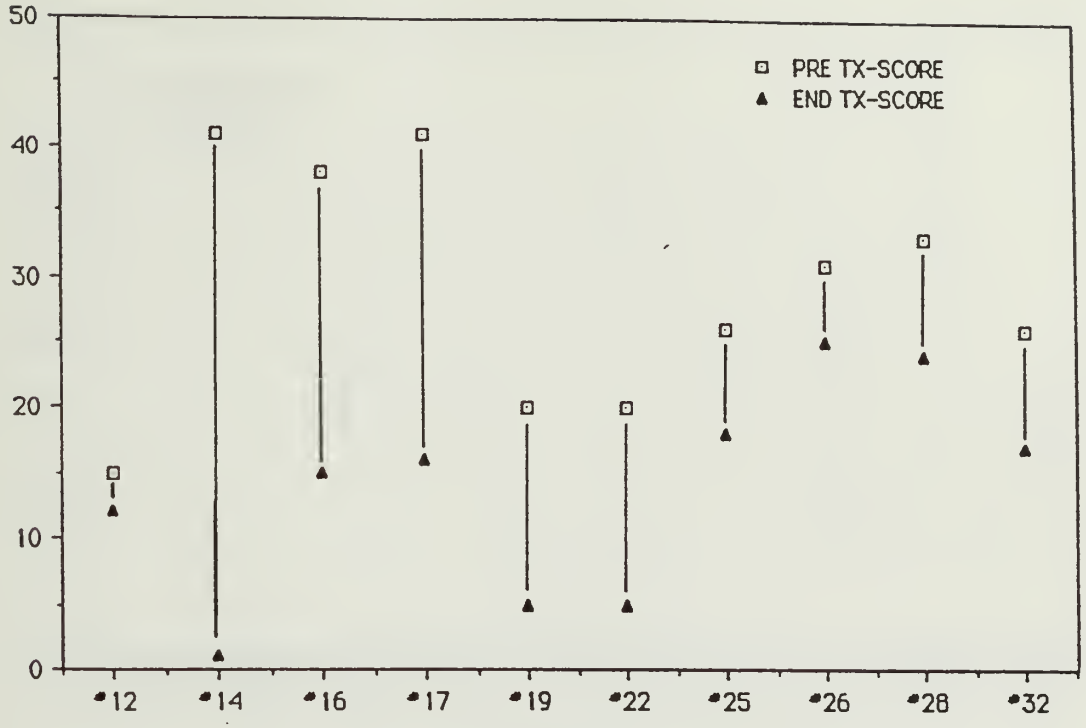
Table 5

Beck Depression Inventory for 17 Subjects Pre-Treatment and End-Treatment Scores Without Subject #14 Who Had a Deviant Score

Paired Samples...

Variable:	Pre-Tx Score	End Tx Score
Mean:	21.94	12.35
Std. Deviation:	11.61	7.02
Paired Observations:	17	

t-statistic:	4.60	Hypothesis:
Degrees of Freedom:	16	Ho: $\mu 1 = \mu 2$
Significance:	< 0.001	Ha: $\mu 1 \neq \mu 2$



Note: Lower BDI score indicates reduced level of depression

Figure 3
Combined Beck Depression Inventory Scores for 10 Subjects Before and After Treatment

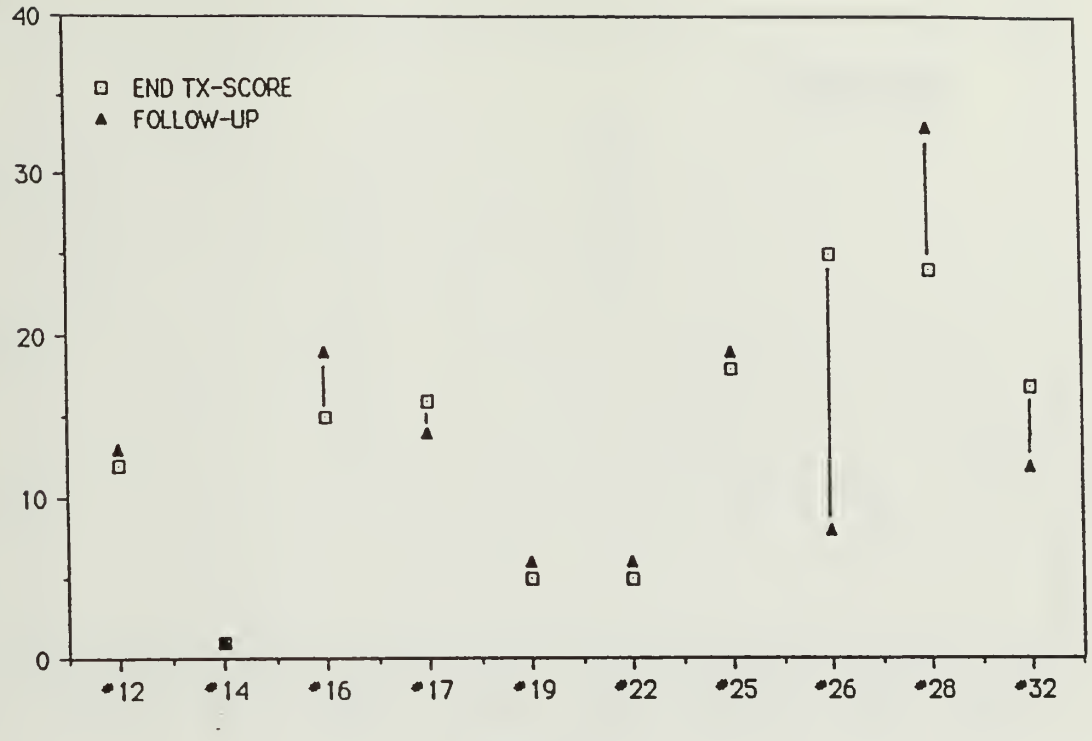
Table 6

Beck Depression Inventory for 10 Subjects (Non-delayed) Pre-Treatment and End-Treatment Scores

Paired Samples...

Variable:	Pre-Tx Score	End Tx Score
Mean:	29.10	13.80
Std. Deviation:	9.22	8.07
Paired Observations:	10	

t-statistic:	4.31	Hypothesis:
Degrees of Freedom:	9	Ho: $\mu 1 = \mu 2$
Significance:	0.002	Ha: $\mu 1 \neq \mu 2$



Note: Lower BDI score indicates reduced level of depression

Figure 4
Combined Beck Depression Inventory Scores for 10 Subjects End and Follow-up Treatment

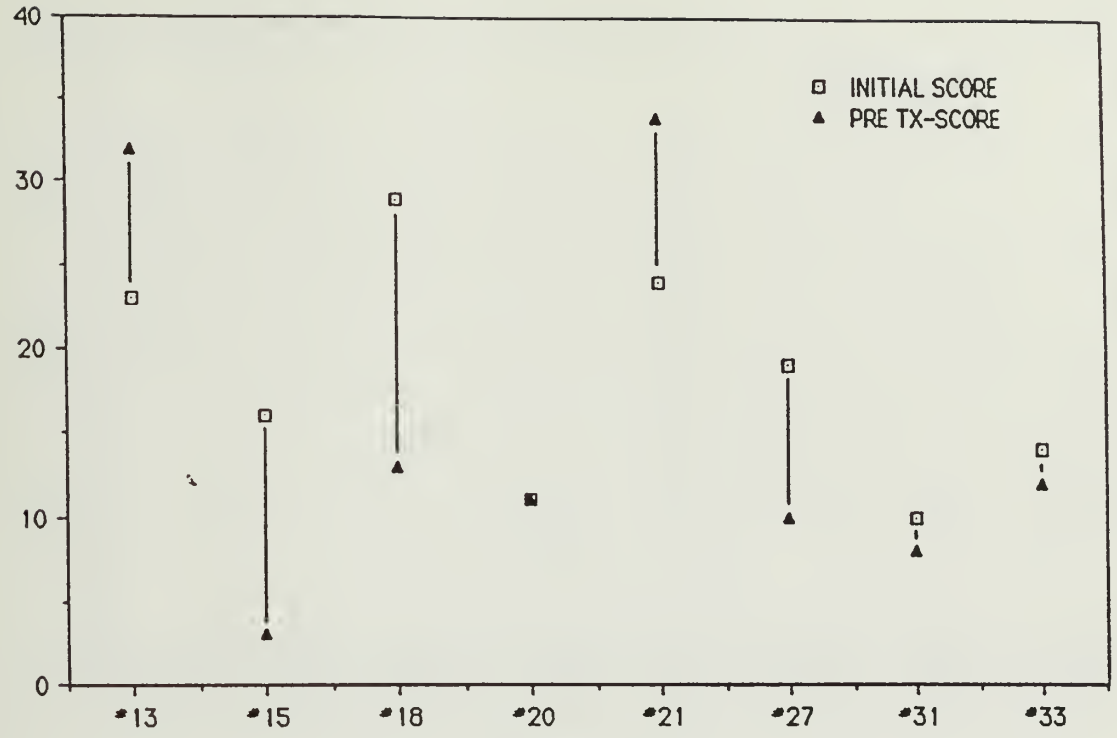
Table 7

Beck Depression Inventory for 10 Subjects (Non-delayed) End-Treatment and Follow-up Treatment Scores

Paired Samples...

Variable:	End Tx Score	Follow-up
Mean:	13.80	13.10
Std. Deviation:	8.07	9.07
Paired Observations:	10	

t-statistic:	0.33	Hypothesis:
Degrees of Freedom:	9	Ho: $\mu 1 = \mu 2$
Significance:	0.752	Ha: $\mu 1 \neq \mu 2$



Note: Lower BDI score indicates reduced level of depression

Figure 5
Combined Beck Depression Inventory Scores for Eight Subjects Initial Phase and Pre-Treatment

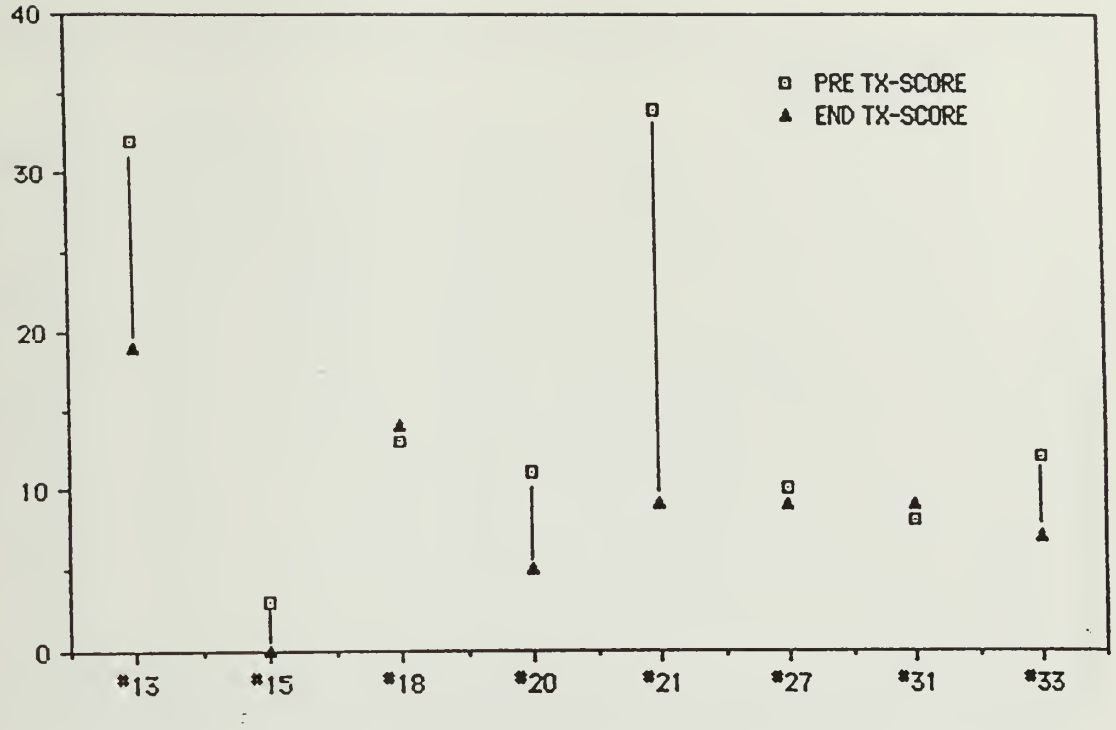
Table 8

Beck Depression Inventory for Eight Subjects (Delayed) Initial Score and Pre-Treatment Score

Paired Samples...

Variable:	Initial Score	Pre-Tx Score
Mean:	18.25	15.38
Std. Deviation:	6.71	11.31
Paired Observations:	8	

t-statistic:	0.86	Hypothesis:
Degrees of Freedom:	7	Ho: $\mu 1 = \mu 2$
Significance:	0.419	Ha: $\mu 1 \neq \mu 2$



Note: Lower BDI score indicates reduced level of depression

Figure 6
Combined Beck Depression Inventory Scores for Eight Subjects Before and After Treatment

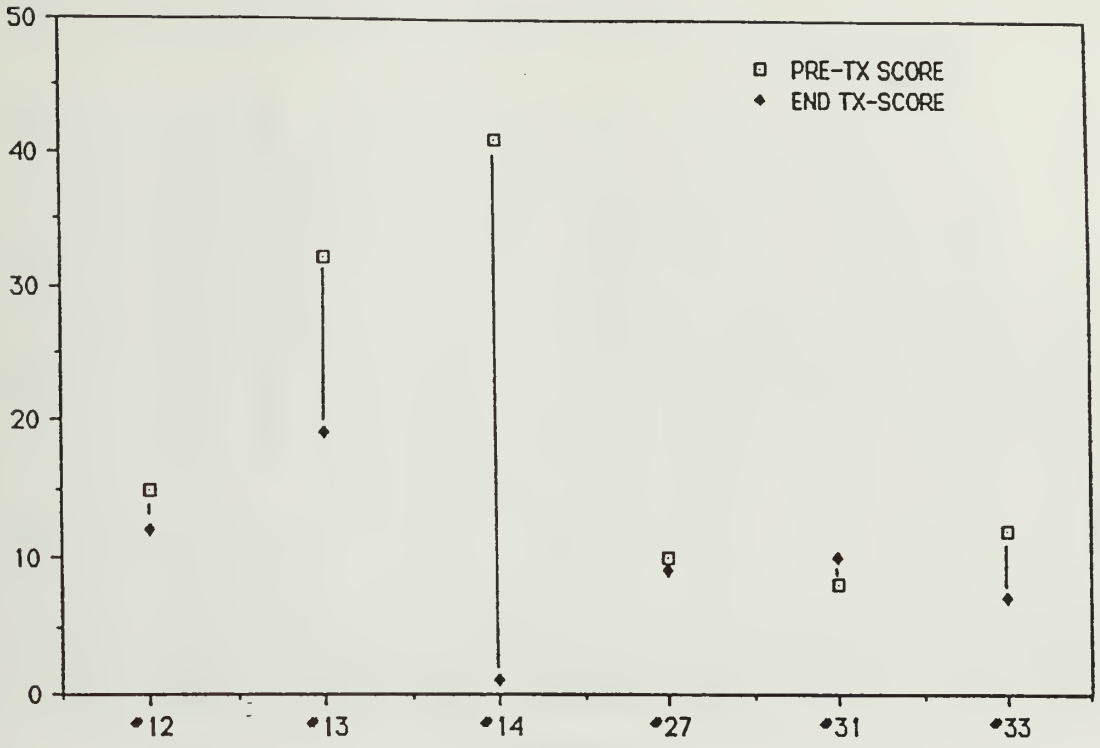
Table 9

Beck Depression Inventory for Eight Subjects (Delayed) Pre-Treatment and End-Treatment Scores

Paired Samples...

Variable:	Pre-Tx Score	End Tx. Score
Mean:	15.38	9.12
Std. Deviation:	11.31	5.69
Paired Observations: 8		

t-statistic:	1.98	Hypothesis:
Degrees of Freedom:	7	Ho: $\mu 1 = \mu 2$
Significance:	0.088	Ha: $\mu 1 \neq \mu 2$



Note: Lower BDI score indicates reduced level of depression

Figure 7
Combined Beck Depression Inventory Scores for Six Males Before and After Treatment

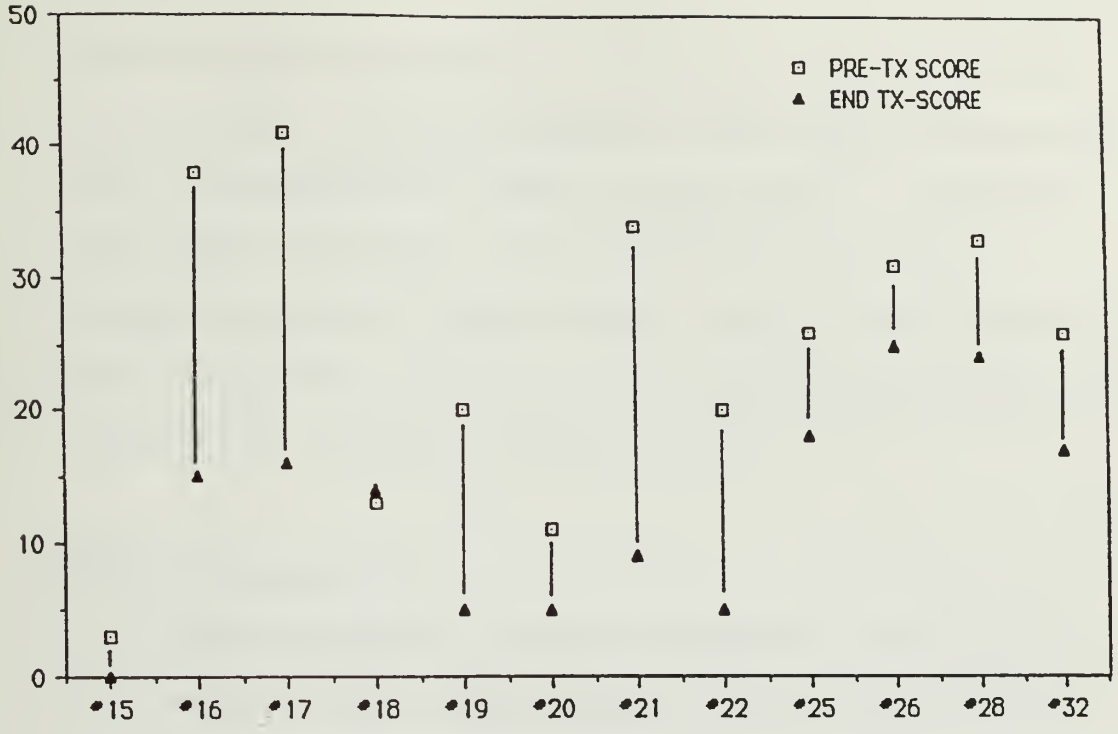
Table 10

Beck Depression Inventory for Six Male Subjects, Pre-Treatment and End-Treatment Scores

Paired Samples...

Variable:	Pre-Tx Score	End Tx Score
Mean:	19.67	9.67
Std. Deviation:	13.54	5.92
Paired Observations:	6	

t-statistic:	1.58	Hypothesis:
Degrees of Freedom:	5	Ho: $\mu 1 = \mu 2$
Significance:	0.176	Ha: $\mu 1 \neq \mu 2$



Note: Lower BDI score indicates reduced level of depression

Figure 8
Combined Beck Depression Inventory Scores for Twelve Female Subjects Before and After Treatment

Table 11

Beck Depression Inventory for Twelve Female Subjects, Pre-Treatment and End-Treatment Scores

Paired Samples...

Variable:	Pre-Tx Score	End Tx Score
Mean:	24.67	12.75
Std. Deviation:	11.60	7.96
Paired Observations:	12	

t-statistic:	4.74	Hypothesis:
Degrees of Freedom:	11	Ho: $\mu 1 = \mu 2$
Significance:	0.001	Ha: $\mu 1 \neq \mu 2$

a group contributed more to the significant differences found in pre- and post-treatment scores than did males as shown in comparison of Table 10 and Table 11. When the data were compared for all three phases, that is, pre-test, post-test and end-test, using all the subjects the supposition of chance is not supported and results of treatment are accepted as significant.

Research Question 2

What personality variables measured by MBTI will compare with differences in changes on BDI before and after experiencing GI?

It was thought that certain personality types would respond better to therapy that involved GI, however, no observable differences were noted between personality variables designated by the MBTI. Of the 18 respondents, an overall 78 percent were introverted and 22 percent were extraverted. Sixty-six percent of males were introverted, sensing types, while forty-two percent of females were introverted, sensing types. Thirty-four percent of all males were found to be extraverted compared to sixteen percent of females. A significant number, eighty-three percent were feeling dominant. The results of the MBTI, compared to the BDI, are presented in Table 12 (See next page).

Table 12

Myers-Briggs Type Indicator (MBTI) and Beck Depression Inventory (BDI)

N=18

Case #	Sex	MBTI Results	BDI Pre-Tx Score	BDI End Tx Scores
#12 (non-delay)	M	ISTJ	(15) Mild mod. dep.	(12) Mild mod. dep.
#13 (delay)	M	ISFP	(32) Extrem.sev. dep.	(19) Mod. Sev. dep.
#14 (non-delay)	M	ISFP	(41) Extrem.sev. dep.	(1) No depression
#15 (delay)	F	ISTJ	(3) No depression	(0) No depression
#16 (non-delay)	F	ISFP	(38) Extrem.sev. dep	(15) Mild mod. dep.
#17 (non-delay)	F	INFP	(41) Extrem.sev. dep	(16) Mild mod. dep.
#18 (delay)	F	INFT	(13) Mod. sev. dep.	(14) Mild mod. dep.
#19 (non-delay)	F	ESTP	(20) Mod. sev. dep.	(5) No depression
#20 (delay)	F	INFJ	(11) Mild mod. dep.	(5) No depression
#21 (delay)	F	INFJ	(34) Mod. sev. dep.	(9) No depression
#22 (non-delay)	F	ISFJ	(20) Mod. sev. dep.	(5) No depression
#25 (non-delay)	F	ENFP	(26) Mod. sev. dep.	(18) Mild mod. dep.
#26 (non-delay)	F	ISFJ	(31) Ext. sev. dep.	(25) Mod.sev. dep.
#27 (delay)	M	ISFP	(10) Mild mod. dep.	(9) No depression
#28 (non-delay)	F	ISFJ	(33) Ext. sev. dep.	(24) Mod. sev. dep.
#31 (delay)	M	ENFP	(8) No depression	(10) Mild mod. dep.
#32 (non-delay)	F	INFJ	(26) Mod. sev. dep.	(17) Mild mod. dep.
#33 (delay)	M	ESFJ	(12) Mild mod. dep.	(7) No depression

Research Question 3

Will self-reports completed three times per week during weeks of treatment and one month after treatment show changes in emotional state and daily living activities?

Figures 9-26 reflect each subject's self-ratings plotted on a graph (See Appendix I, for means of graphs) which includes the slope of the individual scores and the slope of intervention scores as well as a brief summary of each case. Analysis of the intervention and individual means across the graphs demonstrates that at least 17 out of the 18 subjects did change (94%). Out of these, 5 or 28 percent became more depressed, and 12 or 67 percent became less depressed. One subject (5%) remained the same. removing the 10 subjects who were in the non-delayed group, that is, those who received treatment first and then were placed in the baseline phase, 8 (80%) out of the 10 in the baseline continued to improve, 2 (20%) became more depressed.

Each subject's case is described below:

Case #12:

This is a 44 year old man chronically depressed for 10 years who was divorced 10 years ago. He has a 24 year old son. Presenting problem was inability to sustain a

relationship with a woman. He was deeply involved in a relationship that ended during therapy. He was unable to break through his own inner reserve to communicate to his girlfriend his feelings and withdrew from the relationship without attempting to resolve the issues. The high peaks on the charts show the tremendous tension he experienced during that time (6/2-). It also demonstrates that he continued to be depressed after treatment. The lower peaks at the beginning of intervention demonstrate a positive response to treatment. This subject was on a non-delayed program. His scores in the BDI show him to be mildly moderate depressed at the beginning of treatment and the same at the end of treatment.

Case #13:

The subject is an eighteen year old male who admits to sexually abusing two younger children. He came to therapy on his own volition to rid himself of the guilt and shame resulting from these abuses. During therapy he was involved in a relationship that had upsetting dynamics, and at one point, they separated and reunited later. The high peaks in both intervention and non-intervention situations reflect the breaks in the relationship. During intervention he levels out emotionally and achieves some stability. As part of treatment goals, he attended several AA meetings (See Appendix H, for case report).

Case #14:

This subject is a 40 year old male suffering from long-term depression (8 years), who is a Vietnam veteran showing signs of Post-Traumatic Stress Disorder. He has been married for 12 years and has a 7 year old son. Presenting problems are uncontrollable lies which have caused financial difficulties, as well as jeopardizing his marriage and making him feel suicidal. Later, he was diagnosed as having a moderate bi-polar disorder. The high peaks reflect the high level of anxiety he experienced before and right after the beginning of intervention. Mood swings stabilized at the end of the intervention phase and continued to improve during the non-intervention phase. He started the intervention in a high state of depression and finished with a score of no depression on the BDI.

Case #15:

This subject is a 19 year old woman who came for therapy to resolve issues in a relationship with her boyfriend. She denied depression but admitted to suicidal ideation. She was extremely resistant to treatment initially and eventually admitted to being bulimic and feeling shame over this problem. The sharp peaks during the delayed period suggest extreme emotional instability, and upon entering the intervention phase, the same pattern

is noted. She begins to respond emotionally to the intervention by the third session and the sharp peaks begin to level out. She was moderately depressed on the BDI at the beginning of the intervention and ended treatment with no depression.

Case #16:

This subject, a 35 year old female, married with 4 children, came into therapy extremely depressed. Although she had been hospitalized several times, she was unsure of her diagnosis. Later, it was determined that she had a bi-polar disorder, and she was placed on appropriate medications. The chart reflects the manic states by the magnitude of the peaks. There are no variations at all between the intervention and non-intervention phase. After treatment her husband shared that she was no longer phobic (beforehand, she would not go out by herself) or as anxious and fearful. These changes are not reflected on the chart.

Case #17:

This is a 56 year old female suffering from chronic depression and currently on Prozac, an antidepressant medication. She had been struggling with depression since a divorce 10 years ago. She wanted treatment for severe depression, low self-esteem and to deal with the poor relationships she has with her son and her elderly mother.

The baseline mean demonstrates a high level of depression which corresponds to the BDI score of extremely severe depression. The intervention mean and the overall mean stay the same during treatment. The peak during intervention reflects the effects of an incident that occurred between the subject and her daughter-in-law which caused an emotional upheaval. Improvement can be observed after the intervention is withdrawn. However, the emotional stability is not evident as can be seen by the peaks during the non-treatment phase.

Case #18:

This subject, a 36 year old woman, started the study while in the initial stages of pregnancy. She is the mother of five children; the youngest is six years old. Her goal was to be rid of the emotional highs and lows that she's been experiencing and to improve the poor relationships she had with her husband. She score moderately severe depressed on the BDI before any intervention. The mean of the non-intervention phase shows a relatively stable profile; however, during the interventions a sharply accelerating trend is observed. This observation coincides with the subject's own observation of her increasing physical tiredness during pregnancy which elevated her depression feelings.

Case #19:

This 19 year old female was recently rehabilitated from drugs and wanted to recover from co-dependency issues with family, friends and husband. At the end of treatment, she remarked that she really never felt depressed. This is reflected in the flatness of the rating scores and the evenness of the peaks which gradually leveled out altogether. The sharp peak that shows up in the chart at the beginning of the intervention seems to be common for most subjects who experience anxiety prior to treatment.

Case #20:

Childhood traumas brought this 30 year old female to therapy. She explained that she did not feel depressed; however, she agreed to be part of the study. She scored in the mild-moderately depressed scale of the BDI. The baseline demonstrates slightly higher peaks but is generally like her BDI, moderate. As intervention begins, a slightly descending trait is observed.

Case #21:

This 48 year old female is a grandmother. One 16 year old son lives at home. Her goal in therapy was to rid herself of intense fears and phobias, as well as to work out childhood issues with her mother. The higher elevation of the trend during the baseline (no intervention) in comparison with the descending slope when

intervention is introduced suggests that she responded positively to treatment. The BDI shows that she was extremely-severe depressed before intervention and had no depression at the end of treatment.

Case #22:

This is a 50 year old unemployed female with a long history of depressive episodes. Twenty-three years ago, she was hospitalized and placed on antidepressant medication. The most recent inpatient admission was in August, 1989. She is currently on Imipramine, also an antidepressant medication. Her presenting problems were feelings of basic insecurity, and in her words, "everything is falling apart." During the intervention phase, what is seen is a gradually descending slope continuing during the baseline phase. During the non-intervention phase, there appears to be a sharper trend toward steady leveling. She ended up with no depression on the final BDI testing.

Case #25:

This is a 39 year old female with a history of sexual abuse. She is also a recovering drug and alcohol addict. She has three children under the age of seven years. She's chronically depressed and was hospitalized in 1976 and 1979. She was in outpatient treatment for seven years. Currently, she is on Limbitrol, an antidepressant medication. Her goal was to deal with the issues of

sexual abuse and "get off the medication." Her BDI before the program shows her to be moderately-severe depressed. The intervention mean shows a relatively stable descending slope during the treatment and continuing into the base-line phase. This is reflected on her final BDI score which shows her to be mild-moderately depressed.

Case #26:

This 34 year old female had just come out of an in-patient care facility and wanted to be part of the study, but would be leaving for vacation shortly after beginning the program. The intervention was shortened to twice a week for four weeks instead of the six weeks originally planned. She had married an older man and had two children under seven. She was doing a home school program for her daughter and dealing with a hyperactive younger son. She was severely depressed at the start of treatment, and at the end of the intervention, she scored moderately-severe depressed. After the baseline there was no depression. The chart shows the gently descending slope leading to a stable leveling and reflecting the gradual change in her condition.

Case #27:

This 40 year old man had had a recent separation and was in the process of divorce proceedings. He has an eight year old child with his current wife and three older

children from a previous marriage. He is a recovering alcoholic (six years of sobriety) and active in an Adult Children of Alcoholic's program. He came to therapy for help in learning to communicate and manage intimacy with women. He was moderately-severe depressed on the BDI during the baseline phase. The slope shows an upward accelerating trend which continues during the intervention phase. He eventually levels somewhat at the end of treatment, but stays more depressed than at the beginning of the program. Extraneous circumstances (such as a bitter divorce) impacted the results of this study. He did end treatment within a normal range of depression.

Case #28:

This 41 year old female suffers from many physical ailments, the result of the rejections and deep anger in her life. She was seeing at least five medical health people weekly for physical therapy and other kinds of intervention. Her main goal was to work on painful, unresolved issues with her mother who had passed away. Her BDI score shows extreme-severe depression. The slope on her chart reflects the constant level of depression during intervention. This starts to level out after the intervention. Her BDI score at this point becomes moderately-severe depression. After the baseline, the BDI shows again an extreme-severe depression score. She is continuing treatment.

Case #31:

This 56 year old man has been married three times and had recently divorced his third wife which had affected him immensely. He was just getting over this and came to therapy to deal with issues of co-dependency which he felt had caused the problem. His initial BDI score showed him to be mildly depressed, and at the end of treatment showed no depression. The peaks on his graph are highly irregular which suggest extreme mood changes, possibly related to a mild bi-polar disorder. There is a small change from the baseline to the completion of treatment which demonstrates an improvement in depression.

Case #32:

This 40 year old female is divorced and has a son 6 years old. She has a higher degree and is now working on a degree in theology. Her goal was to get in touch with her emotions and to build a relationship with her mother. The BDI score before intervention showed her to be moderately-severe depressed. The unusual trend on her graph concurs with her impressions of not being in touch emotionally. It shows a flat affect with basically no changes during intervention and very slight change in the baseline, i.e., the delayed phase of treatment. Her score on the BDI after intervention shows some improvement; she is now mild-moderately depressed.

Case #33:

This 50 year old man was brain-damaged as a youth in a motorcycle accident. He had to re-learn cognitive functions and continues to be delayed in certain skills such as writing and organization. Another friend was killed in the accident, and he wanted to work on the guilt associated with the accident and his "low feelings" about himself. The BDI shows him to be mildly depressed at the beginning of the baseline. After intervention, his score on the BDI is no depression. The low level on the BDI could be indicative of two factors, one his low intellectual functioning or a low level of depression. The slope shows a gradually decreasing level of depression, but the affect remains flat.

Research Question 4

What part of the treatment of the sessions will the subject see as positive and what part as negative?

The reason for asking this question was to allow the subjects as clients to give their impressions and opinions on what they thought was important to them during the treatment phase of the program (see Appendix J, for all the questions and answers). The responses to the questions were presented in percentiles.

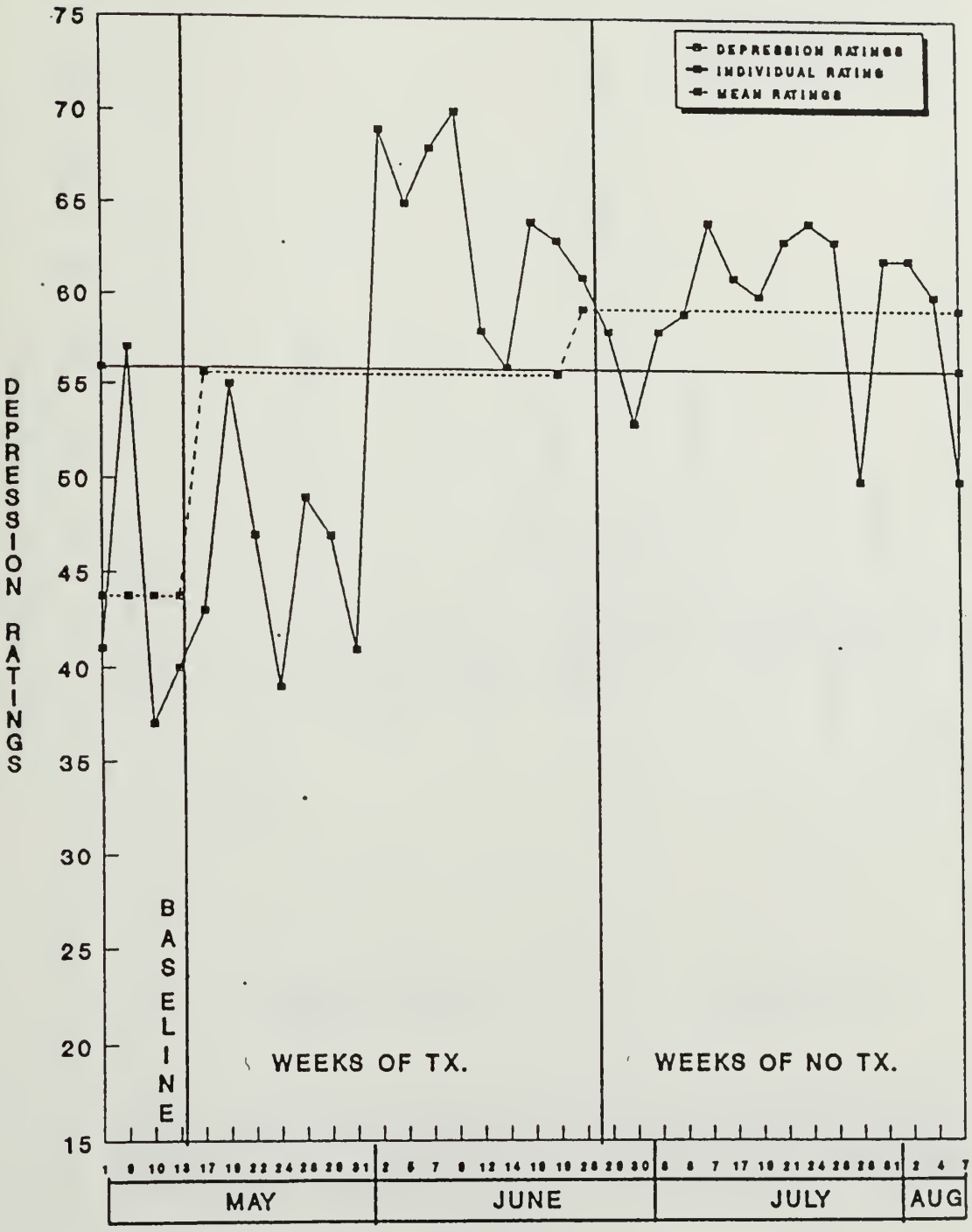


Figure 9
Depression Rating by Subject 12

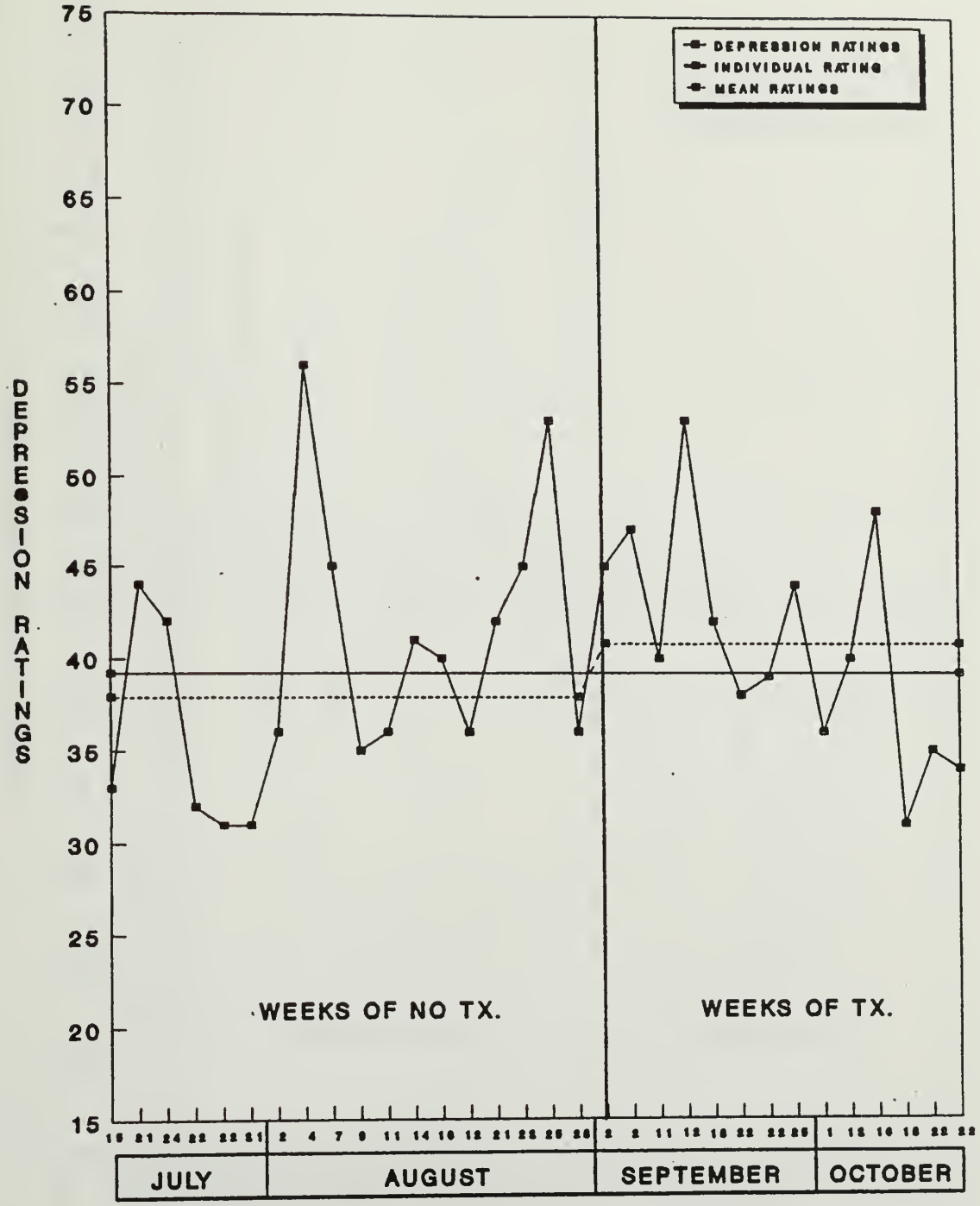


Figure 10
Depression Rating by Subject 13

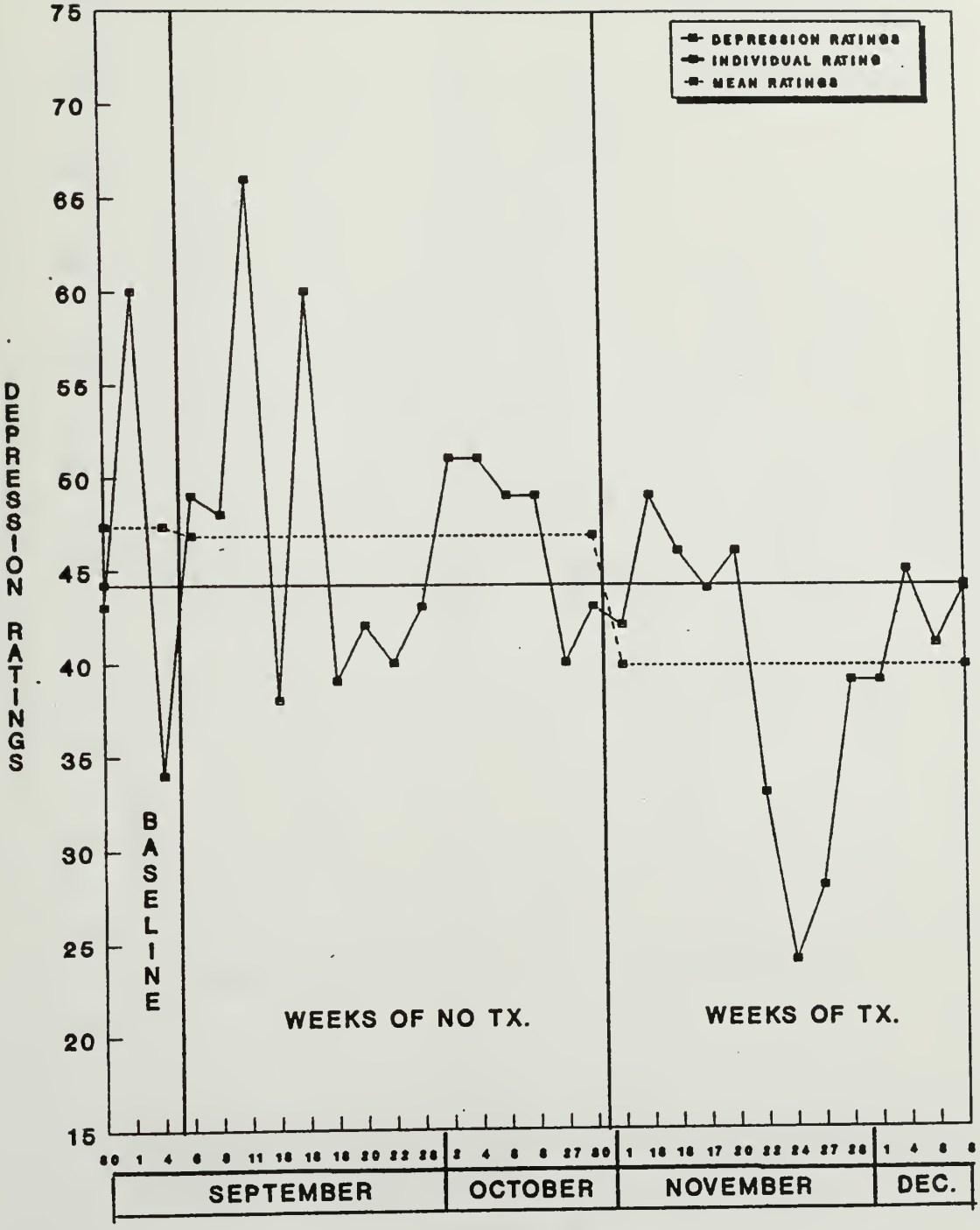


Figure 11
Depression Rating by Subject 14

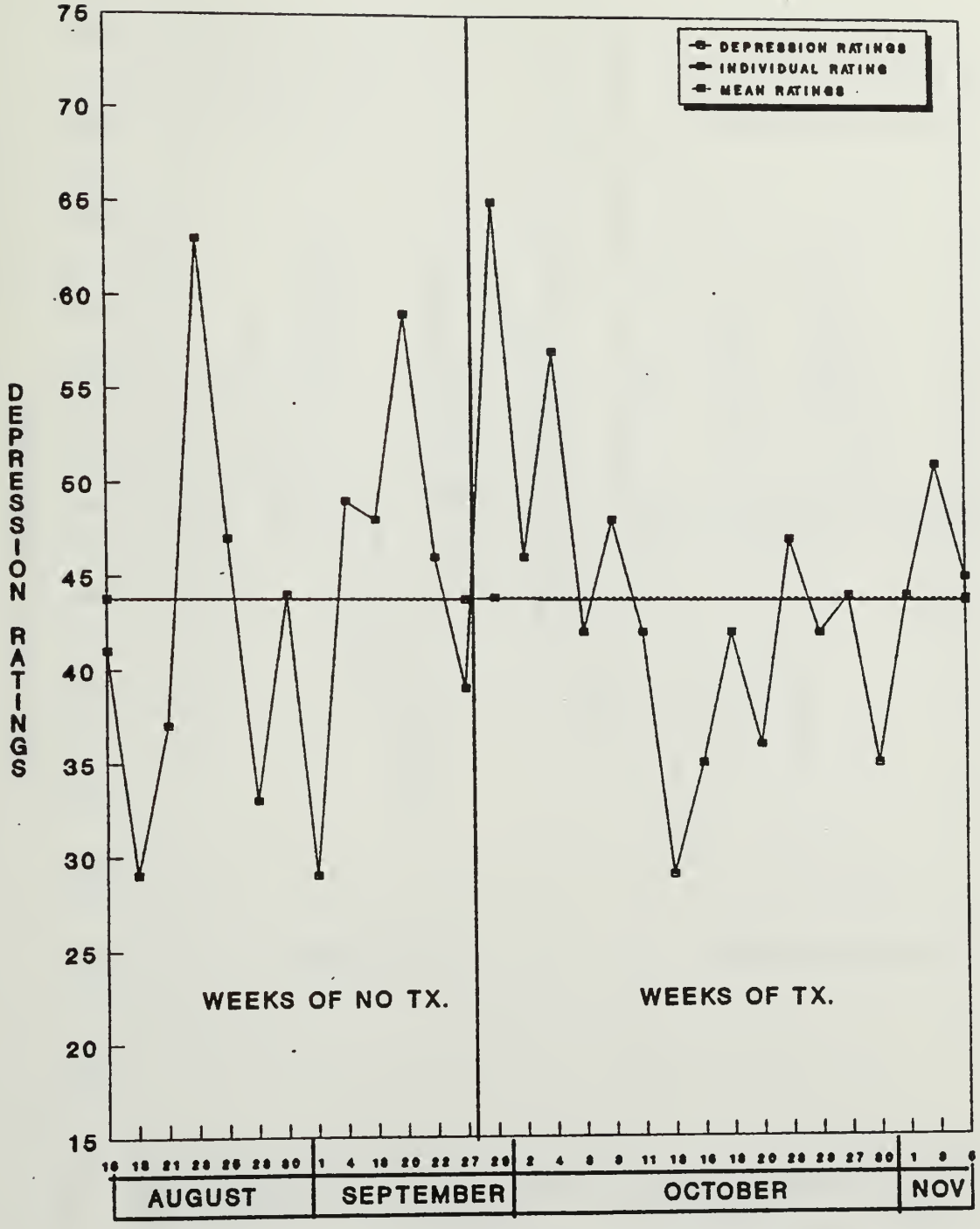


Figure 12
Depression Rating by Subject 15

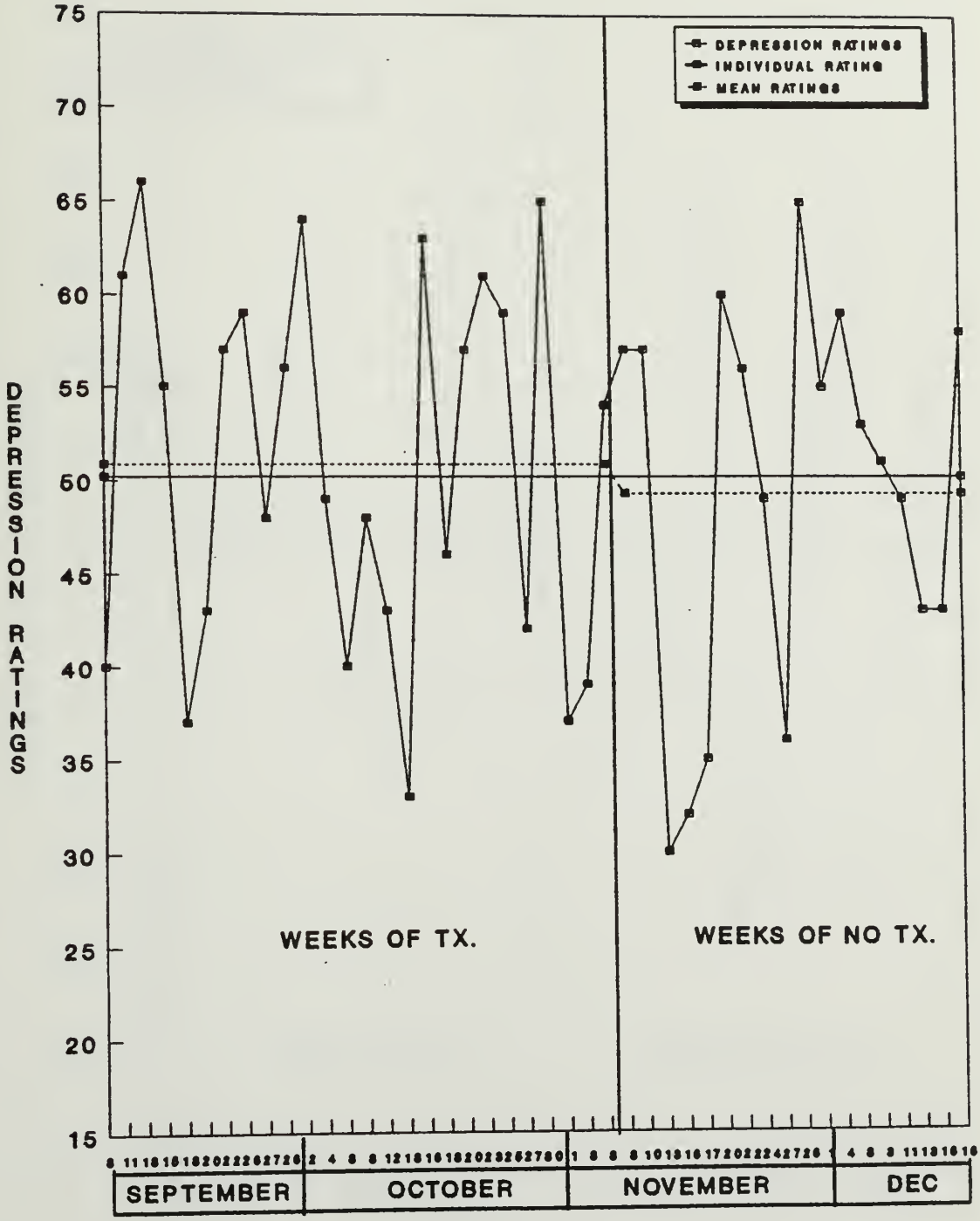


Figure 13
Depression Rating by Subject 16

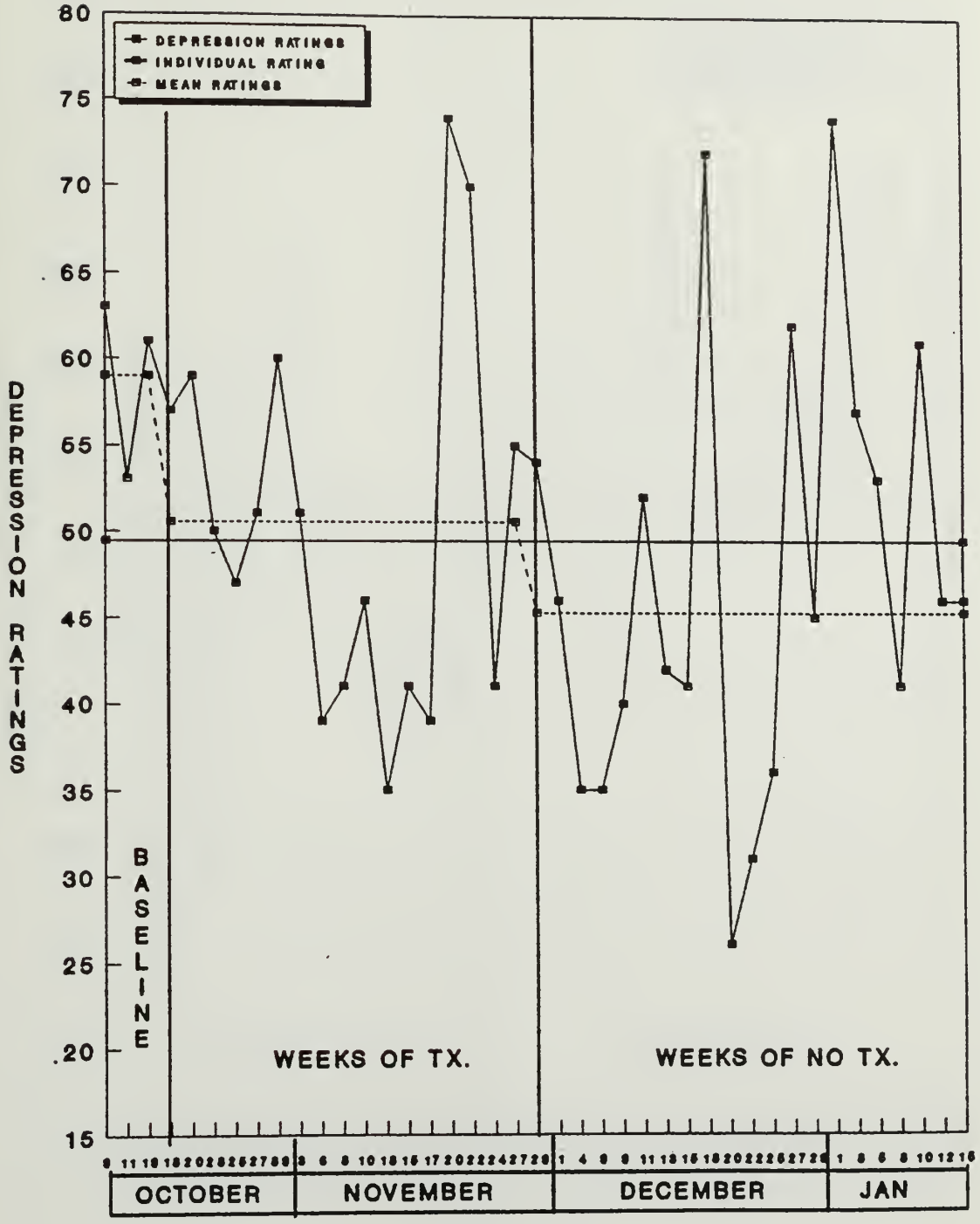


Figure 14
Depression Rating by Subject 17

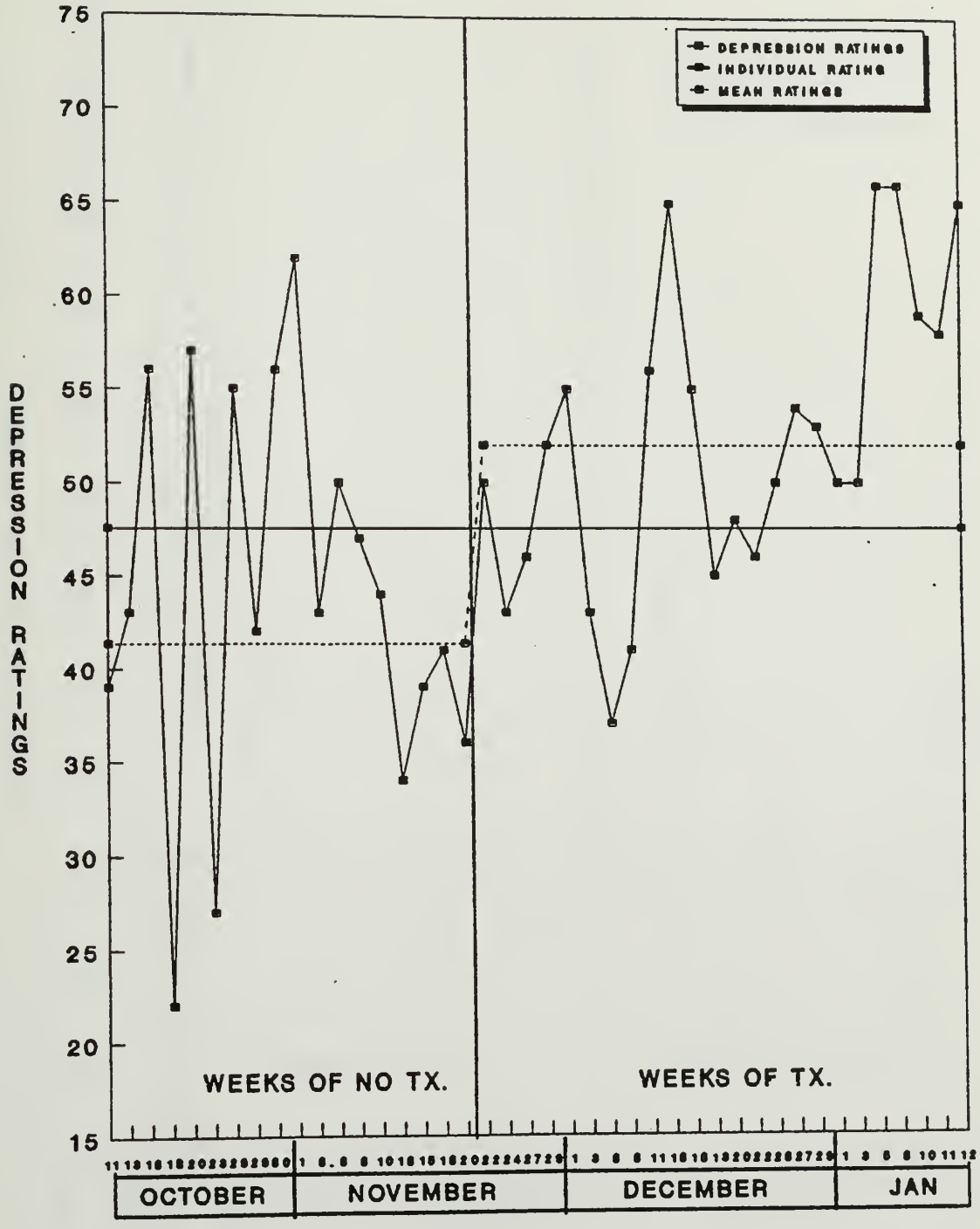


Figure 15
Depression Rating by Subject 18

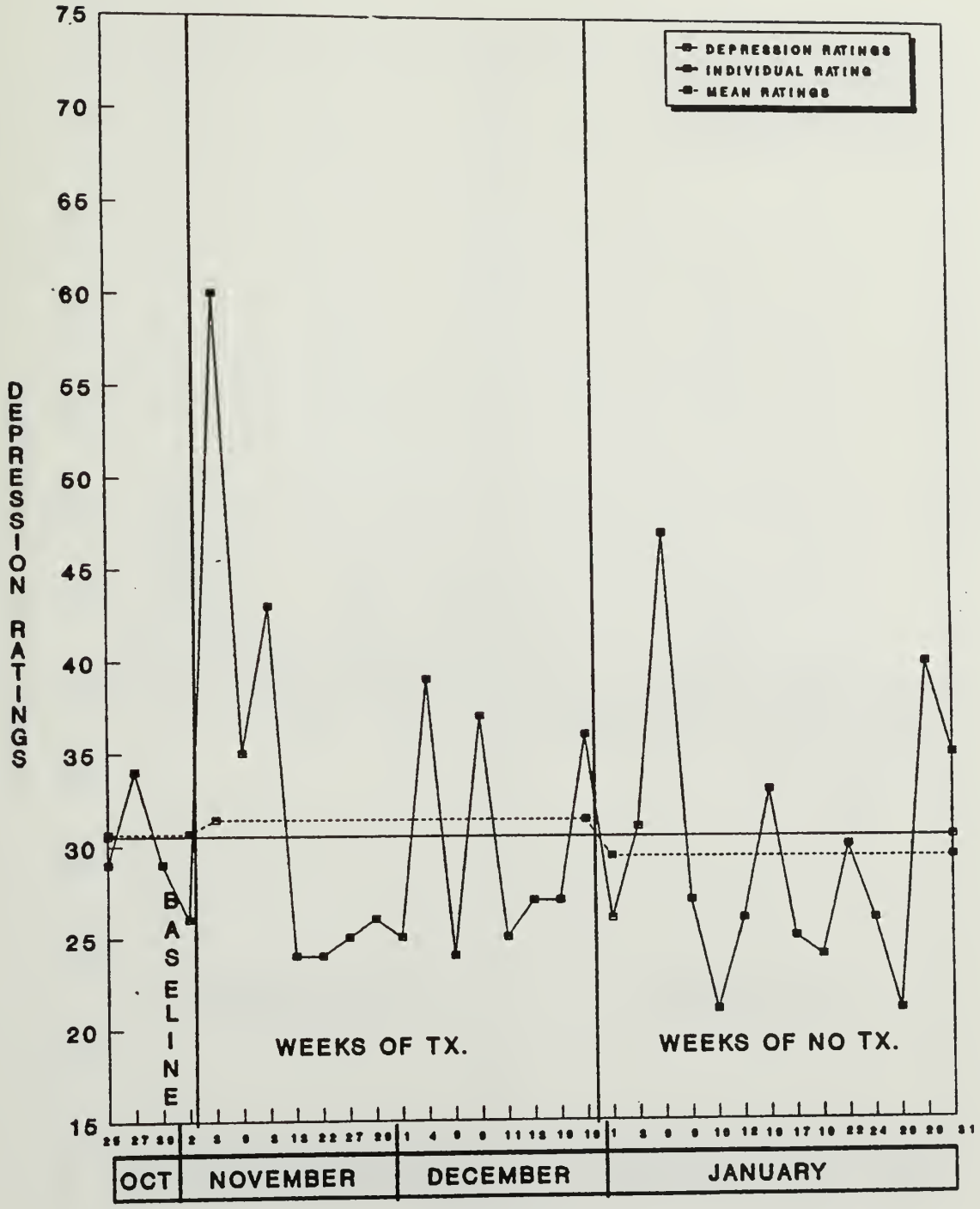


Figure 16
Depression Rating by Subject 19

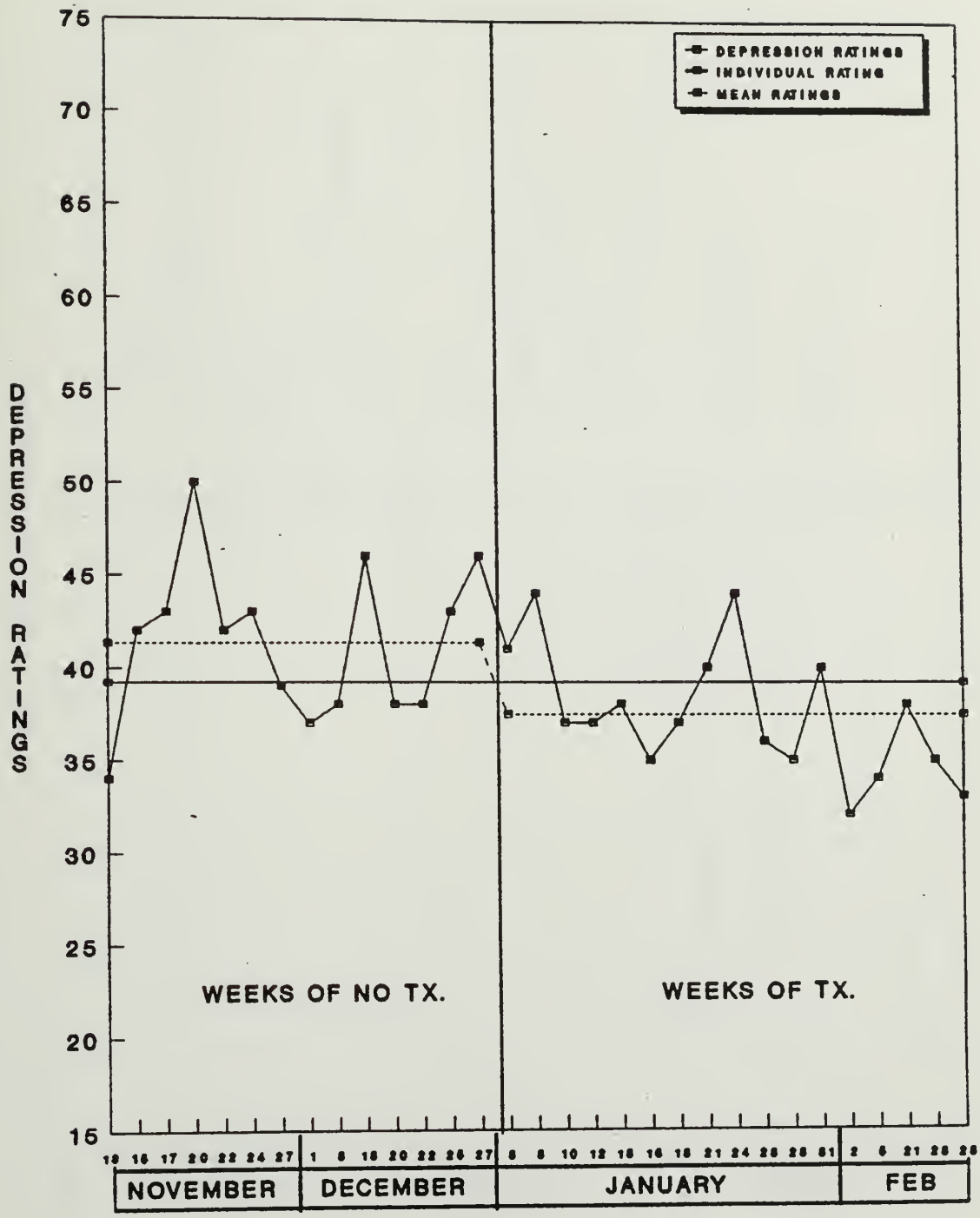


Figure 17
Depression Rating by Subject 20

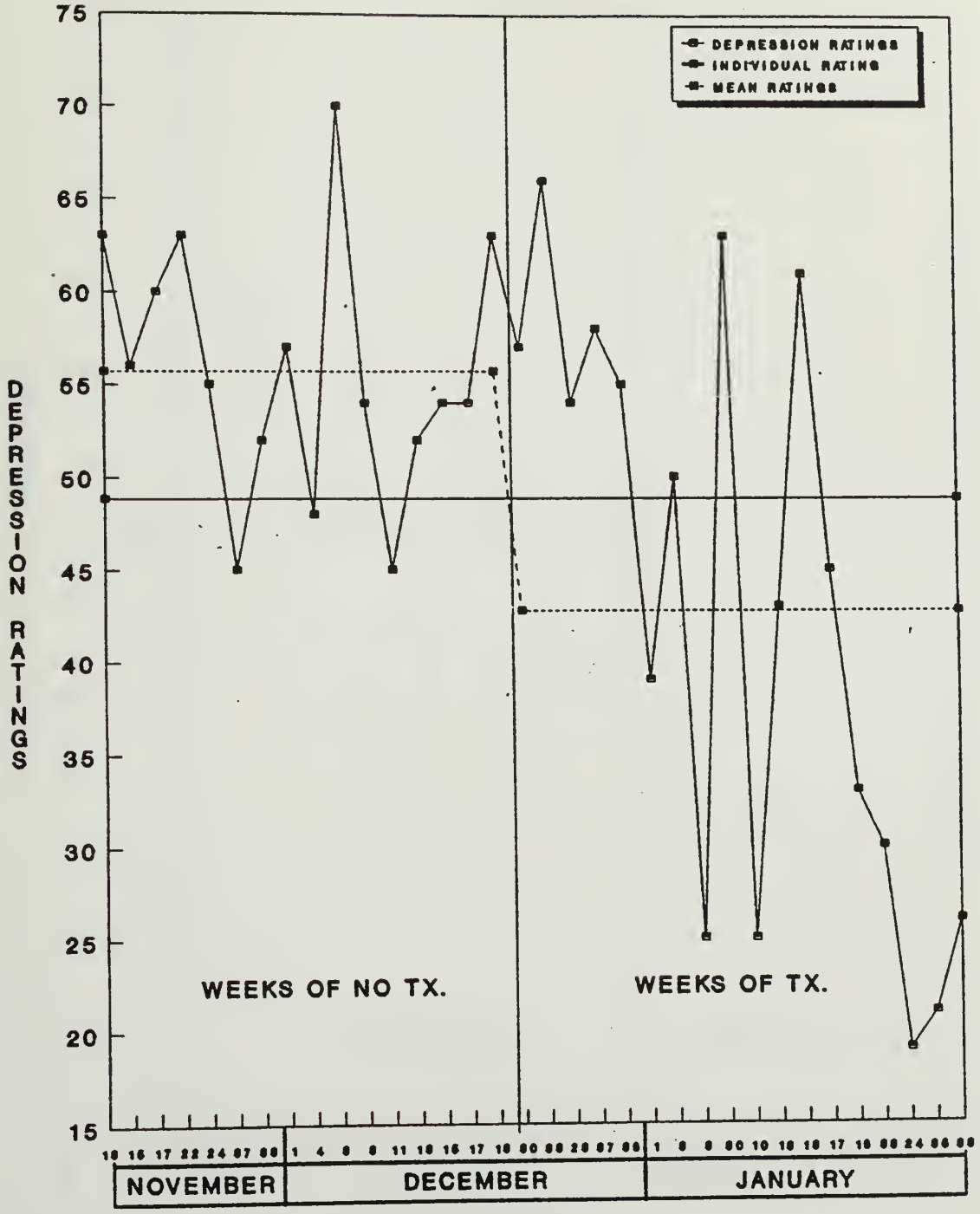


Figure 18
Depression Rating by Subject 21

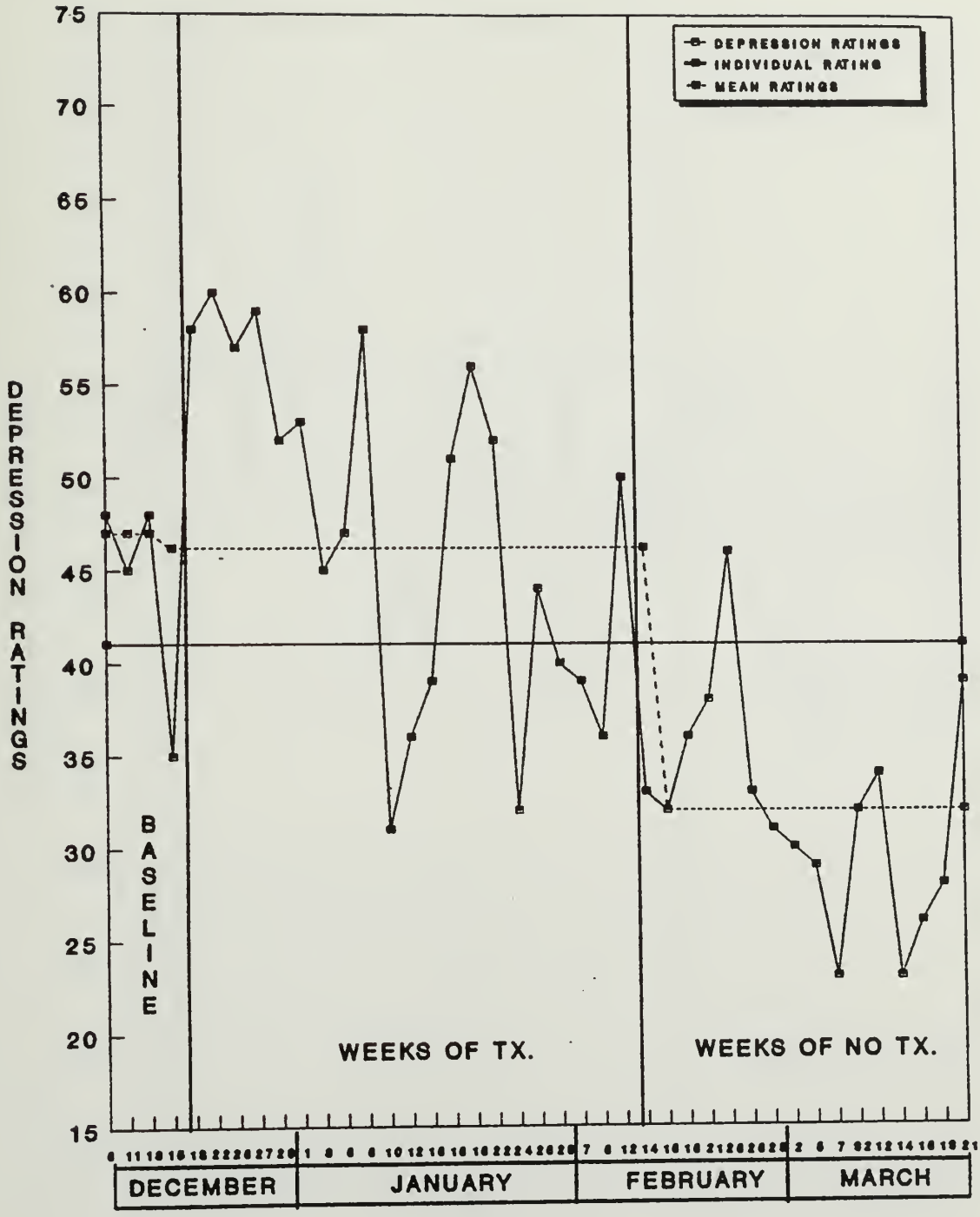


Figure 19
Depression Rating by Subject 22

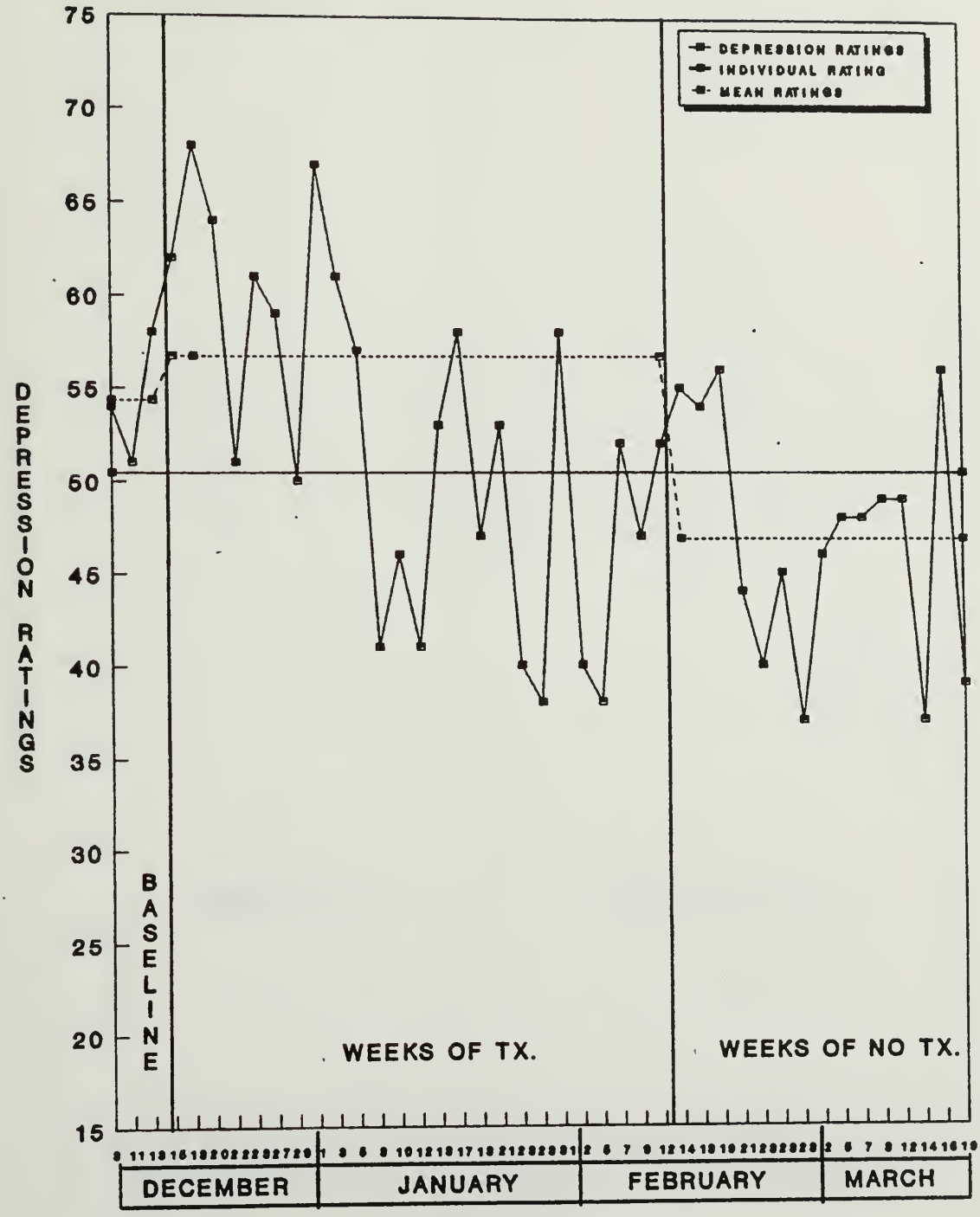


Figure 20
Depression Rating by Subject 25

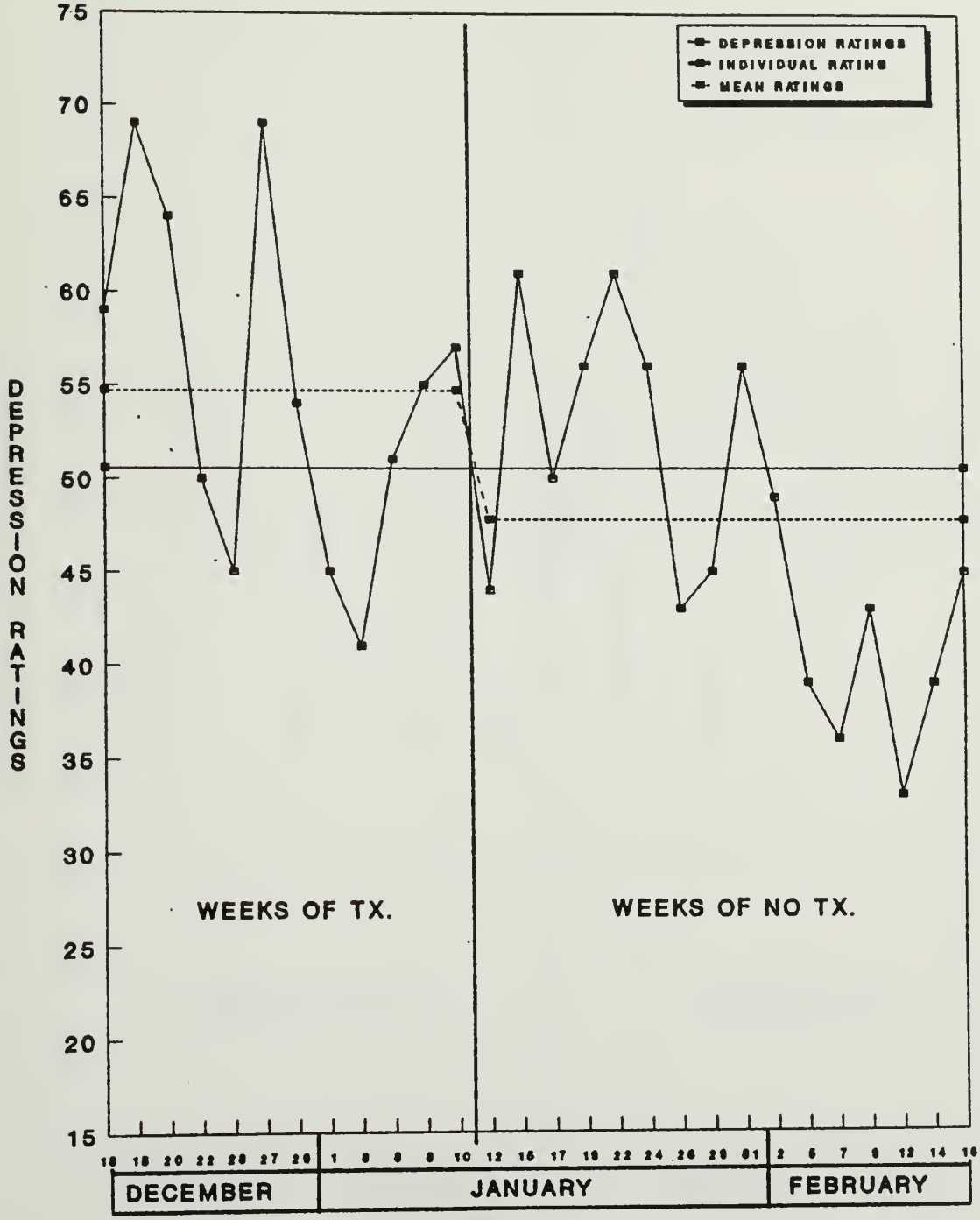


Figure 21
Depression Rating by Subject 26

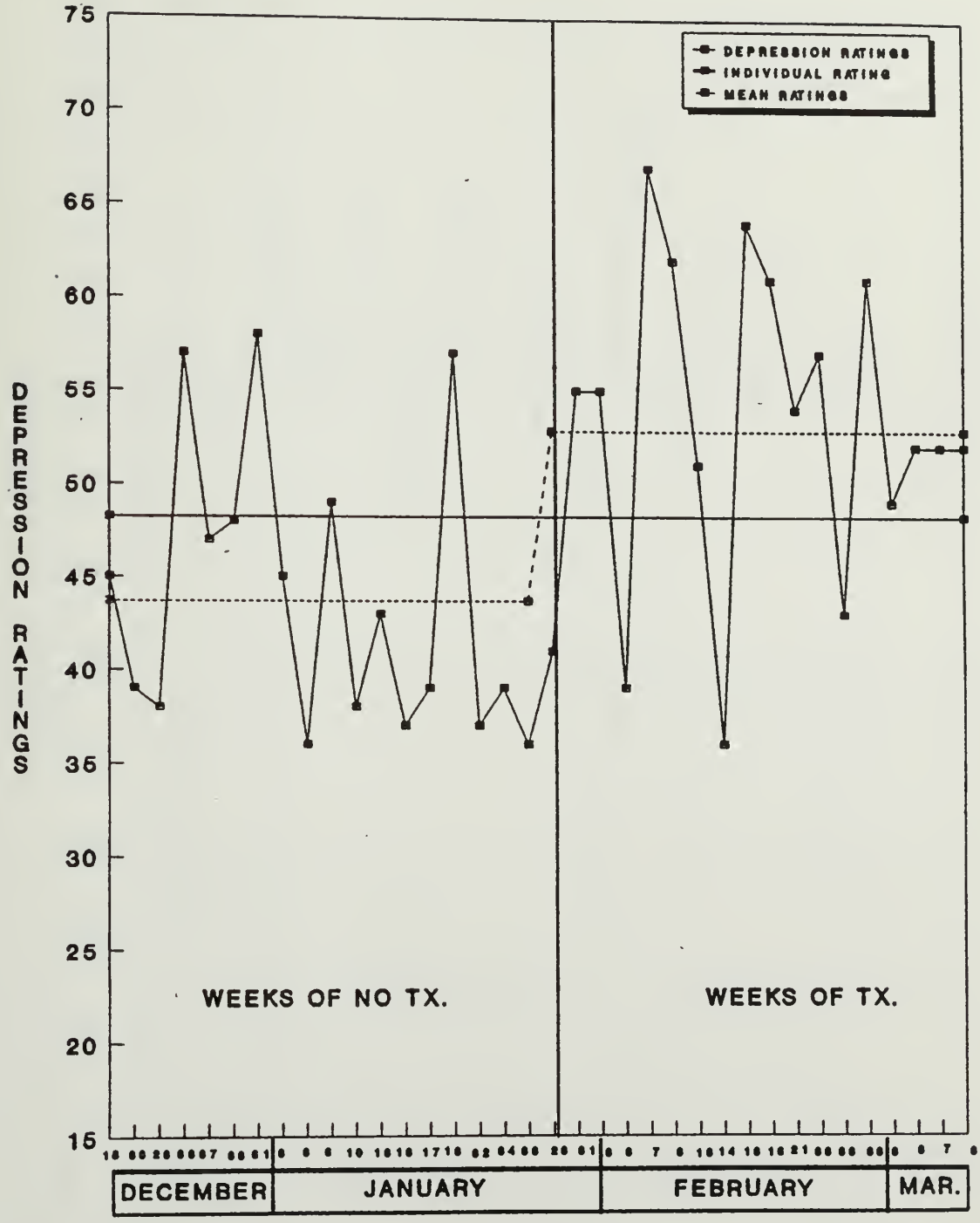


Figure 22
Depression Rating by Subject 27

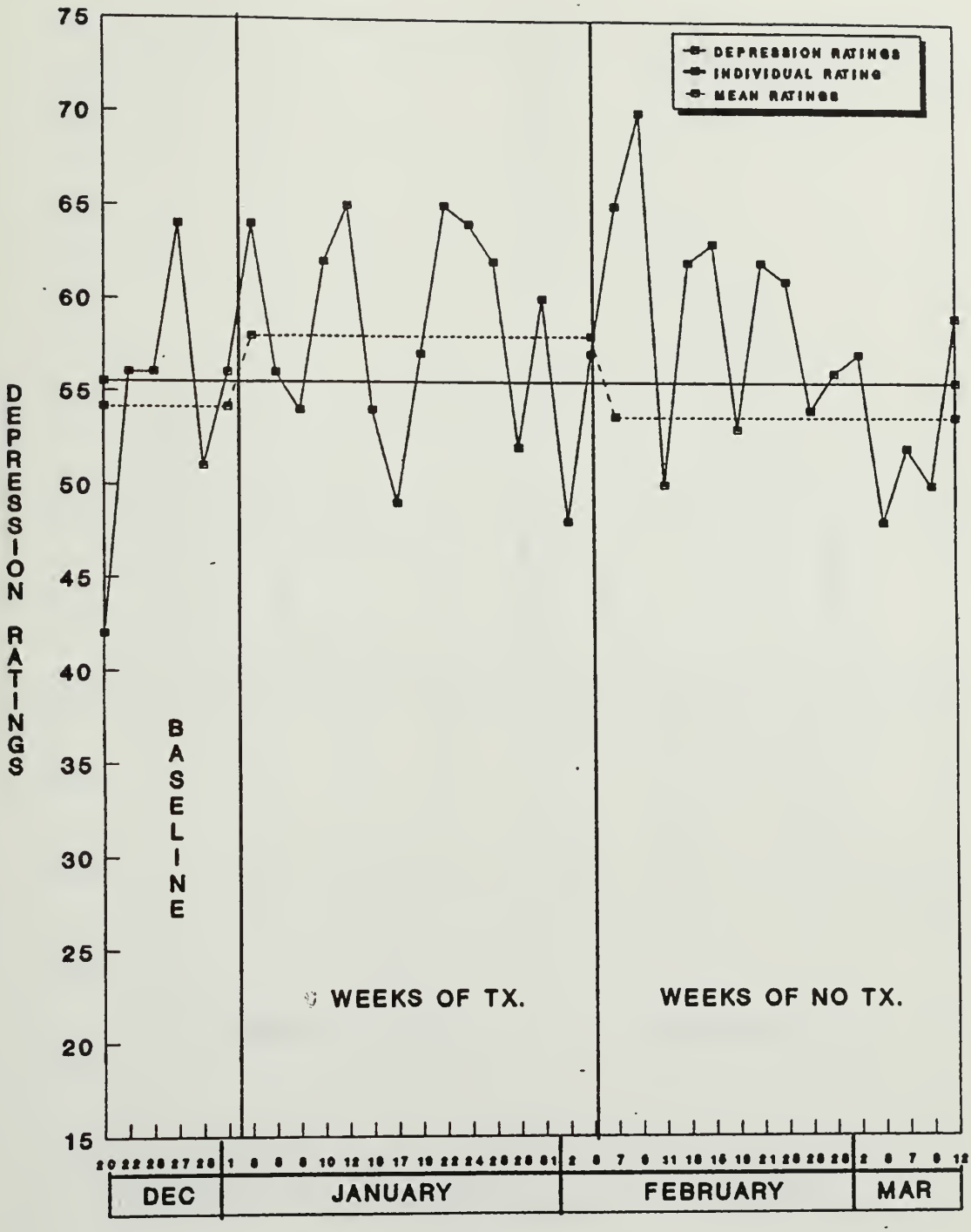


Figure 23
Depression Rating by Subject 28

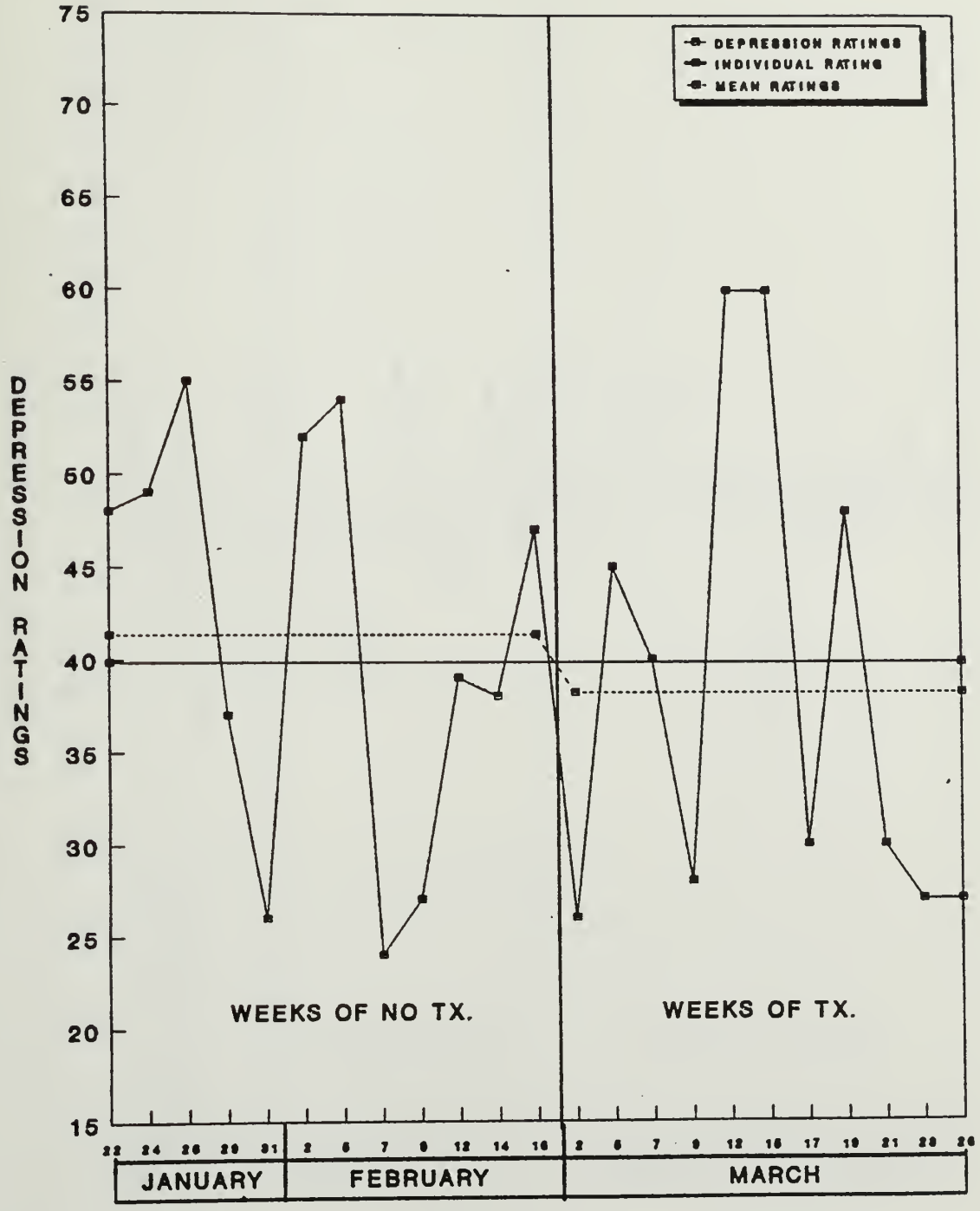


Figure 24
Depression Rating by Subject 31

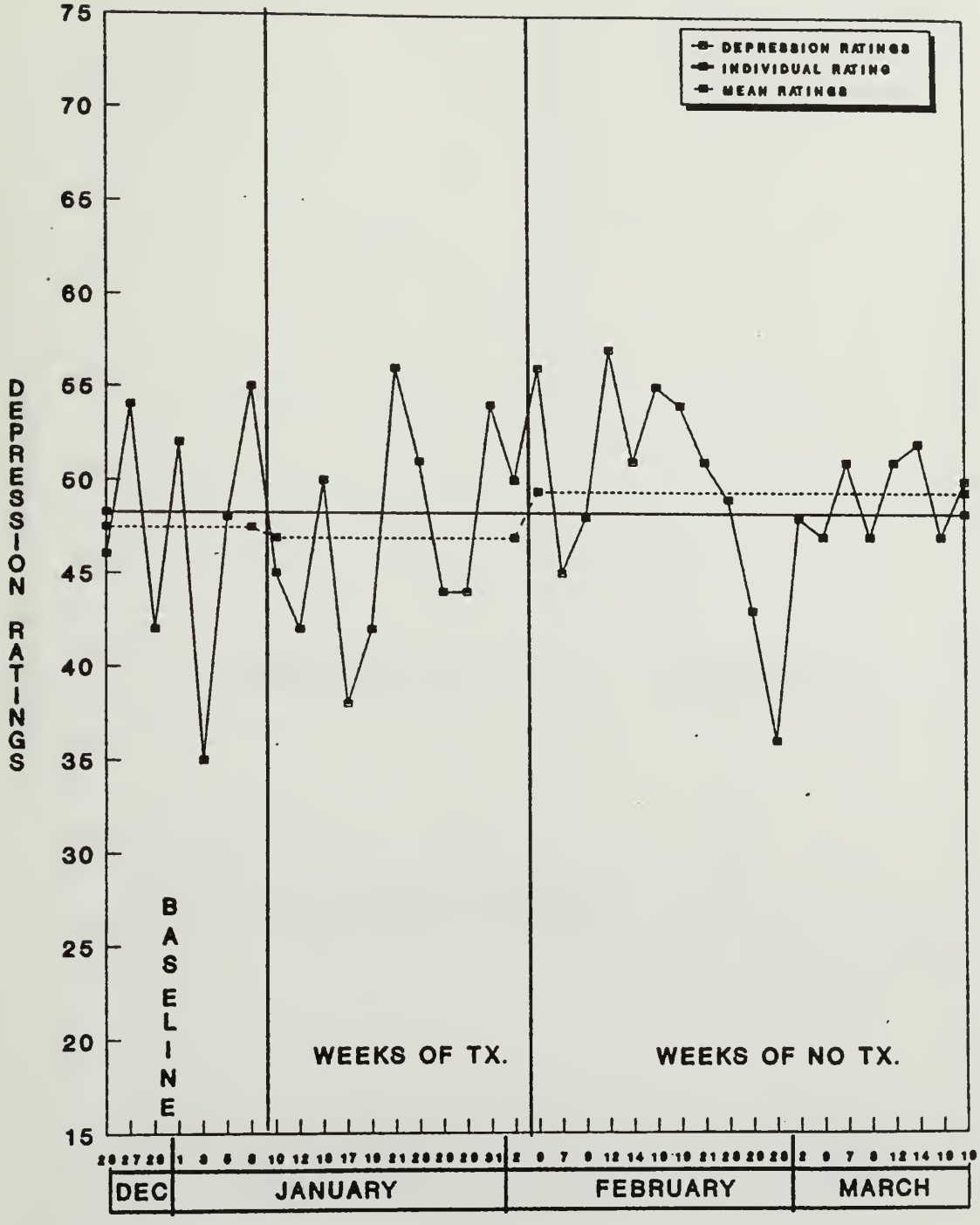


Figure 25
Depression Rating by Subject 32

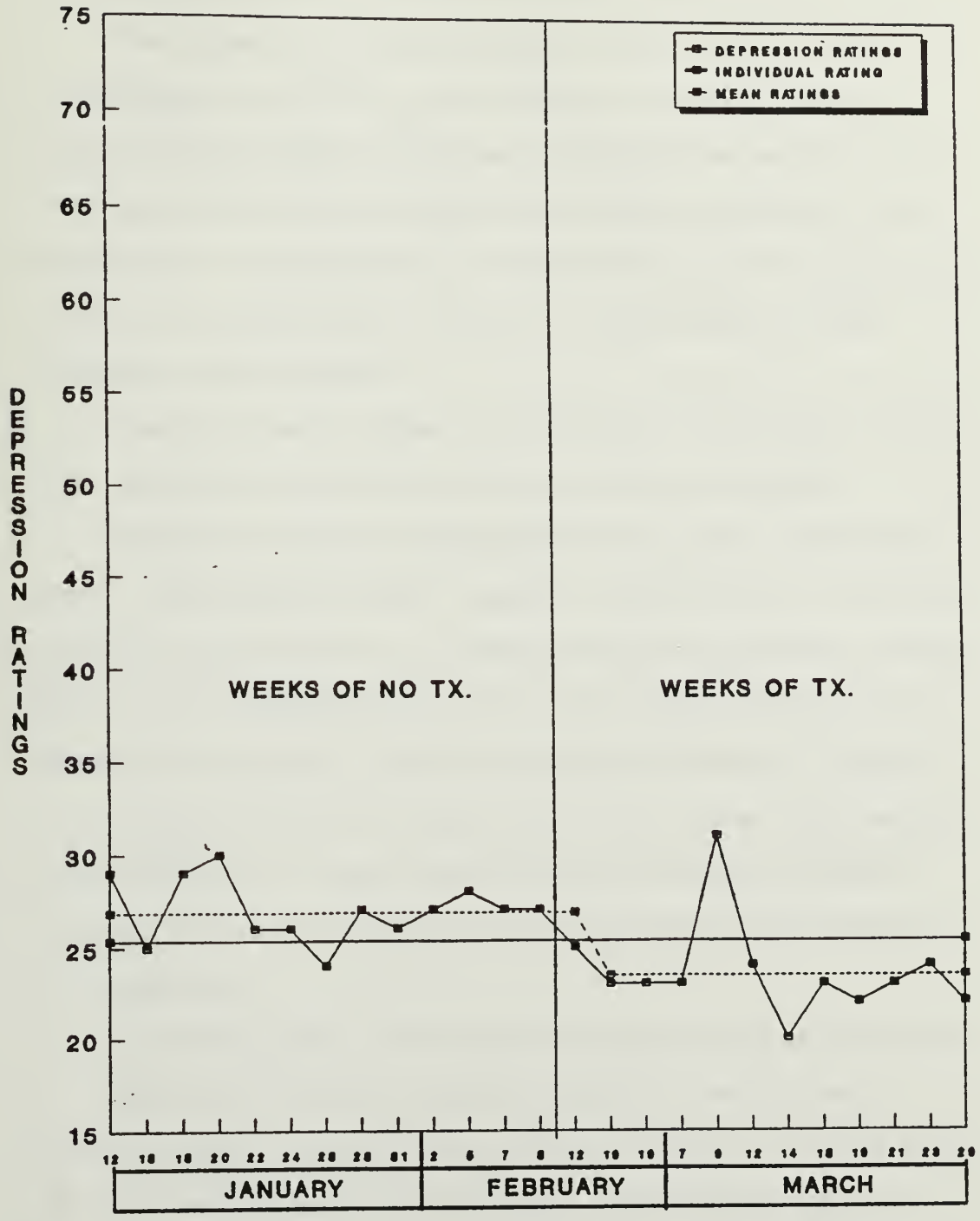


Figure 26
Depression Rating by Subject 33

Question one: In what way did counseling help you?

The answers to this question were so varied that it is necessary to refer to the results in the appendix. There was one common response, thirty-three percent said that they were able to communicate their problems to the therapist. An example is, "I was able to work through and talk about some issues." Another subject said, "Just talking to her helped."

Question two: Among the different techniques used by your therapist, which ones did you like the best?

Fifty-five percent answered that imagery was important. One subject said, "Imagery, particularly in dealing with the child within." Another subject answered, "Going back to the childhood and also by having myself in situations with my mind, going to different places." Five of the subjects (27%) mentioned that both prayer and imagery were important. Prayer and religious themes were mentioned by sixty-one percent of the subjects as important in treatment.

Question three: What was the worst part of therapy?

Basically, thirty-eight percent of the subjects answered that confrontation with the truth or facing pain was the hardest part of therapy. About eleven percent found feelings of guilt difficult. One subject said, "My own resistance to conceptualizations which conflicted with

pre-held biases on my part." Symbolic of the responses is the answer, "Feeling the pain and feeling overwhelmed by it sometimes."

Question four: In what way did your depression improve, increase or stay the same?

Fifty-five percent of the subjects said there was definite improvement. Two, or eleven percent, of the subjects said that they did not feel depressed to begin with. Some of the subjects (28%) said that depression varied from day to day.

Question five was: Did the prayer each session help, and if so, in what way?

A large percentage (89%) answered in the affirmative. Thirty-three percent answered that they felt peaceful. Eleven percent said they felt the healing of God. The rest of the responses varied from, "It released a lot of tension, and it got me thinking into improving my life," to, "It made me realize how hard I had been fighting Christ."

Question six: Would you recommend the kinds of things your therapist used to a friend who is dealing with similar issues?

One-hundred percent answered that they would recommend this therapy to a friend.

Summary

The results of the data analysis reveal that for the delayed and non-delayed subjects, as measured by the BDI, depression was reduced. Statistical analysis, using Student's t-test, produced statistically significant findings in decreasing depression as recorded by the BDI. Personality variables did not appear to predict those who would be susceptible to depression on the MBTI, nor did it predict who would be more successful on the BDI or the self-report ratings. A subject's introversion or extraversion tendencies appear to have little or no influence on test results. The design of the self-report was successful in fulfilling its purpose which was to mark changes in daily moods and behaviors. Furthermore, self-report ratings of depressive feelings or thoughts did show discernible increases or decreases following treatment. On the evaluation of treatment, eighty-eight percent of the subjects responded to treatment with positive affirmations about the use of imagery and prayer.

CHAPTER V

DISCUSSION

Summary of Results

The purpose of this study was to examine the effectiveness of Guided Imagery (GI) when used in conjunction with Christian psychotherapy to reduce depression in adult subjects. Given the complexity of the numerous dynamic interactions (between client and therapist) and the different methods involved in a therapeutic situation, it was difficult to develop a measuring instrument that would provide reliable data regarding the success or non-success of using GI. The two basic instruments used were the daily-rating which provided a weekly check on the variations of moods and behaviors and the Beck Depression Inventory (BDI), a standardized instrument used to collaborate what was observed to be happening on the daily ratings. The four research questions were designed to structure the study and provide additional information.

The first research question asked whether levels of depression, measured by the BDI before and after experiencing the GI sessions would change beyond what might be expected by chance. Statistical analysis of the BDI scores at different times during the experiment indicated changes did take place. Pre-treatment and post-treatment

scores on the BDI were significantly different ($P<0.001$). Guided Imagery as part of a psychotherapeutic treatment appears to have an impact on depression as measured by the BDI. However, it does not prove that GI was the influential factor. All that can be postulated is that subjects' ratings on the BDI did change significantly. As mentioned beforehand, it would be difficult to isolate a specific variable that caused the changes. Specifically, this study lacked the ideal control situation using a different treatment set as a comparison. Elkin's (1985) study, which did a comparison between four different treatments, found that two treatments of the four had equal effects. One was good "clinical management" (concern for the client) with placebos and the other was a psychotherapeutic approach resulting in improvement mostly in mildly depressed clients. The GI method used by this researcher does involve a loving and involved concern. With the GI and prayers, subjects were inclined to feel better both about themselves and the therapist (See evaluation answers in Appendix J.) The results of the BDI on some subjects show striking changes from extremely depressed to no depression, especially case number 14, and moderately severe depression to mildly depressed (#19; #22). These changes could be attributed to the "halo effect" where subjects not wanting to displease someone they like (the

researcher) would rate themselves less depressed, especially on the BDI after treatment (Anastasi, 1976). Another consideration is the number of subjects in this study. Kazdin (1982) recommends at least twenty subjects for this type of study. This study finally ended with eighteen participants, eight dropping out for various reasons. Even with a research study of this size, it is believed that sufficient conclusions and information has been obtained to make a number of suggestions for further research.

The second question asked what personality variables, as measured by the MBTI, might be more susceptible to the use of GI in lowering depression. There were far more introverts (78%) than extraverts (22%) in the total of eighteen subjects who took part in this study. Introverts are sensitive to "the contrast between their ideals and their actual accomplishments; that they burden themselves with a sense of inadequacy." Thus, if according to the MBTI guide, they do not find a means of expressing their ideals, they may be "overly sensitive and vulnerable" (Myers & McCaully, p.25). Another speculation posits that introverts, because of their particular psychological nature, may get more depressed. Although 43 percent of introverted subjects went from various states of depression to no depression, there is insufficient

evidence to make a conclusion as to the connection of different personality types.

The third question asked whether self-ratings on mood changes completed three times per week during the weeks of treatment and for one month after treatment would show changes in emotional state and daily living activities. The self-report rating scale was taken from the DSM-III-R diagnostic criteria for depression. Each of the items on the scale was submitted to independent raters for comparison to DSM-III-R criteria. A reverse order of questions was formulated so that not all the questions point to negative responses and also to avoid the measures being contaminated by the responses set. The subjects were encouraged to stick to the schedule which was set for Mondays, Wednesdays and Fridays after 7 p.m. One subject whose presentation on the graph shows a tremendous magnitude of rapidly changing peaks from high to low, was diagnosed as manic-depressive (Bi-polar disorder), and she demonstrated no change at all. The changes occurred in areas not covered by the graph, such as fewer panic attacks and phobias. Some subjects who said they were not depressed at the initial interview showed significant levels of depression on the BDI before treatment and also on their self-reports.

The self-report ratings done by the subjects are susceptible to a number of errors (i.e., S's in denial of feelings). Interestingly, many subjects included personal comments as to why they answered the way they did on the self-report. They included comments such as "bad day," "fight with boss" or "lost job" to explain their mood that day. The self-rating instrument was designed to measure weekly changes in moods and behaviors. The ratings on the self-report showed a decline of depression, but not as much as the BDI. The data was placed on graphs for a visual presentation of the three phases -- baseline, intervention (non-delayed), and non-intervention (delayed). However, the initial baseline measure before treatment for the non-delayed was dropped because three self-reports by the subjects were insufficient for a valid and stable rating. The non-intervention phase was the baseline for the non-delayed group. For the delayed group, no baseline was established for after-treatment scores. To fit the graphs on the paper, it was necessary to compress the time on the X-axis and to expand the ratings on the Y-axis. This accents the changes in the ratings and creates the optical illusion that peaks are higher than they actually are. Treatment conditions were assigned to several subjects who later dropped from the research so that the order of non-delayed assignment of subjects

versus delayed is not balanced over time. The counter-balance design was maintained but at staggered intervals. Putting the data on the graphs helped the researcher identify two subjects who had a mild bi-polar disorder and were unaware of this problem. The information was shared with subjects at the appropriate therapeutic time.

The fourth question asked the subjects to evaluate the treatment. For many subjects, the use of prayer and GI was important. What the researcher noted was the intensity of the short-term therapy, and, in retrospect, the pain it caused many of the subjects, even though, at the end, they thought it worthwhile. The duration of six to eight weeks of therapy expedited the process of evaluating the treatment; however, for many subjects, the end of therapy came at an inopportune time in their process of recovery. Instead of this short period of treatment (six to eight weeks), a longer period of therapy might have been affective for the subjects. The six-question evaluation form was administered while the therapist was out of the room. This does not eliminate the "Halo" effect because they were aware that the researcher would eventually read them. One female subject, who was critical in her evaluation, said that she would recommend this therapy to her friends. She also continues seeing this researcher for further treatment.

Conclusions

The study was successful in its goal to explore the reduction of depression through the use of GI in Christian psychotherapy. This study would be of value to clinicians interested in researching this area because the information provided herein might be used to supplement other new research. For example, this study revealed that more introverts (78%) than extraverts were involved in treatment. How other personalities would respond to GI can not be answered in this study, although we can say that the four extraverted subjects did not differ significantly in depression BDI scores from the introverts. A research study by Gralton, Hayes and Richardson (1979) on individual differences in the use of imagery found that introverts experienced imagery more vividly and produced better performances on tasks of verbal learning. These findings suggest that introverts might differ not only on tasks involving verbal learning, but in other behavioral tasks as well. Studies related to these questions would require a larger population of different personalities than what was utilized here. This researcher believes that such an effort might produce significant results. It would also be beneficial to investigate why more women than men responded positively to GI treatment. A study by Sheehan (1967) evaluating the Bett's questionnaire on

mental imagery reported that females tended to have more vivid imagery than males. It also could be suggested that women on the whole are more susceptible to hypnotic states (Sheikh, 1983) and more open to the imagery processes. Another possibility is that women might have easier access to right-brain processing (McGuinness & Courtney, 1983) and therefore to imagery (Sheikh, 1983). Sheikh (1983) comments on a study by McClellan (1975) that looked at the role of imagery in the developmental maturity of of men and women. McClellan implies that the use of imagery in men becomes less important as they mature and differentiate; while in women, even as they mature, imagery continues to play an important role throughout their lifetimes.

Several methodology issues have surfaced during the study. One, the baseline for non-delayed subjects was too short to establish a trend in self-ratings before treatment was initiated. This was not known beforehand; however, it did not impact the study because the subjects in the delayed treatment phase demonstrated a baseline. It was also expected that the subjects would have been composed of individuals representing different MBTI personality types. A repeated single subject design does permit replication; however, having just one researcher makes it difficult to filter out among the many variables,

the therapist, the music, the imagery, etc., the key factors that made the treatment results. Generally, most studies have several researchers trained in a certain manner that reduces the impact of therapist characteristics. In the study by Propst (1980), subjects were assigned to either a religious imagery treatment, a non-religious imagery treatment, a non-directive placebo treatment, or a waitlist control group. She stated, "non-Christian therapists were deliberately used to control for therapist's expectations that one treatment would be better" (p.111). Propst found that subjects who were still depressed on the BDI, the religious imagery group, showed a significantly lower score than the other groups.

There is some attempt in this study to study procedures that are unique to Christian psychotherapy. These procedures include the use of inner healing which is described earlier in this study and the use of prayers involving the gifts (charisms) of the Holy Spirit.

This study is one of the few that attempted to look at the mechanics of how Christian psychotherapy functions and how prayer is utilized in that setting. What can be ascertained is that the empirical effect of GI and prayer can not be isolated from other variables that may have worked therapeutically in this study. Anecdotically, participants were surprised at the power of prayer in

their lives. The findings from this study suggest that this type of therapy is a viable alternative for Christians in treating depression.

APPENDICES

APPENDIX A

ADVERTISEMENT

APPENDIX B

EVALUATION QUESTIONNAIRE

DERRY NEWS - December 6, 1989

WANTED: Adults experiencing depression to take part in a research/treatment project
No salary. Confidential.
434-0494 after 7p.m.

EVALUATION QUESTIONNAIRE

Subject #_____

Date_____

1. In what way did the counseling help you?

2. Among the different techniques used by your therapist, which ones did you like the best?

3. What was the worst part of therapy?

4. In what way did your depression improve, increase or stay the same?

5. Did the prayer each session help, and if so, in what way?

6. Would you recommend the kinds of things your therapist used to a friend with similiar issues as yours?

APPENDIX C

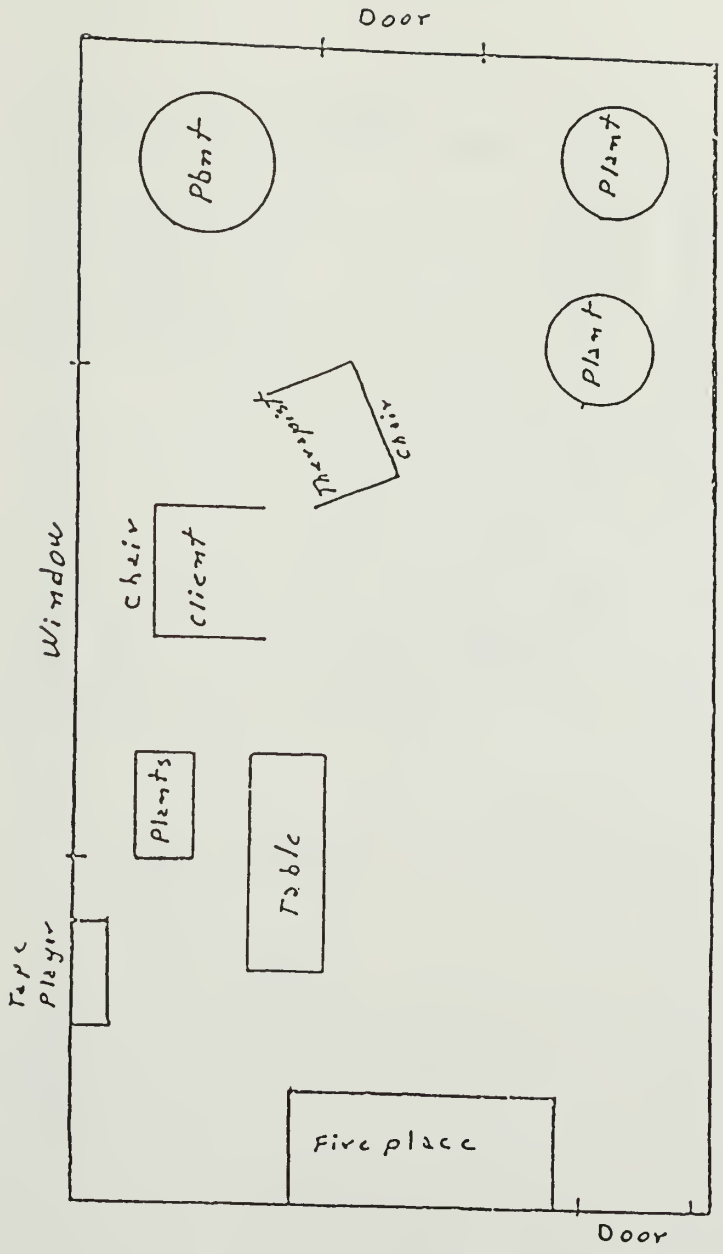
MUSIC LIST

MUSIC LIST

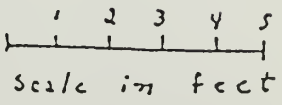
Spirit Alive	Songs of the Healing Spirit Monks of Weston Priory, Vermont
A Touch of SH AL AVAH	Shalavah Records Nashville, TN
Come to the Quiet	John Michael Talbot Sparrow Records, Canoga Park,CA
He's Worthy	St. David's Praise Group St. David's Episcopal Church Jacksonville, FL
Reflections	Instrumental Music by the Dameans NALR, Phoenix, AZ
For God and God Alone	The Sparrows Corporation

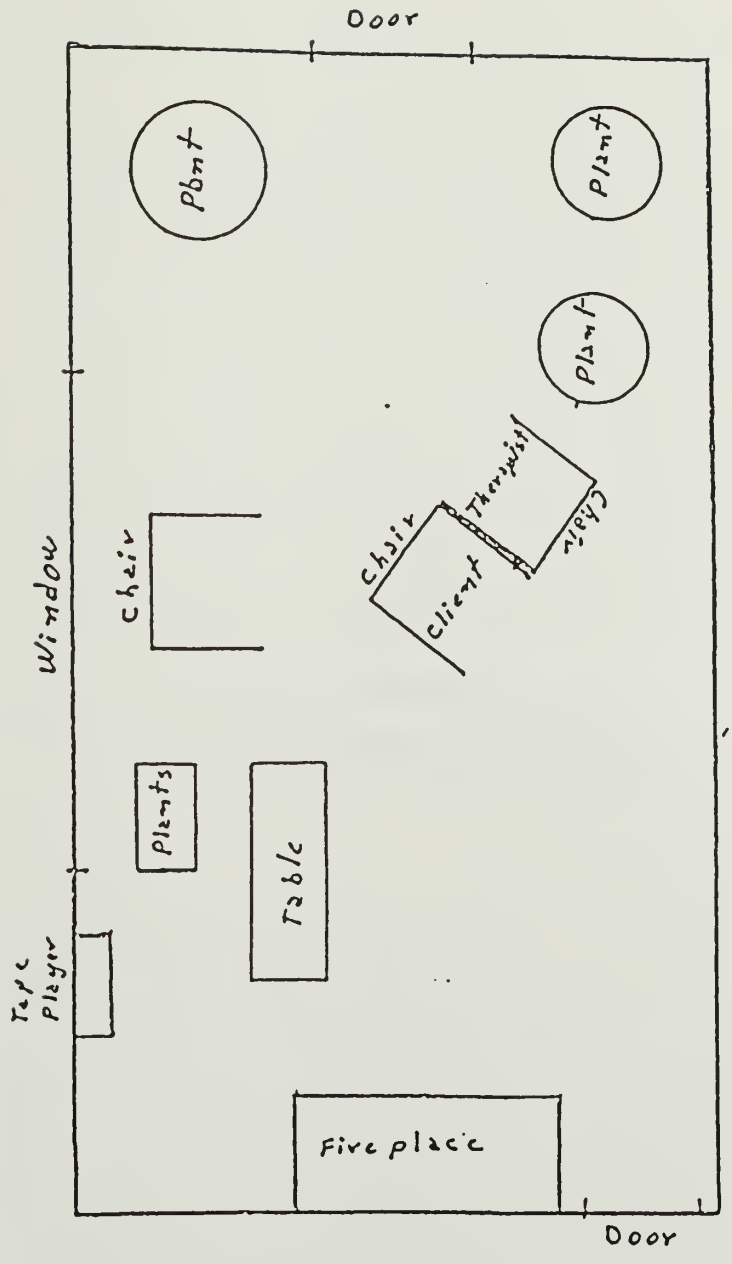
APPENDIX D

ROOM DIAGRAMS

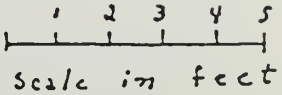


Situation #1
Interview





Situation #2
Guided Imagery



APPENDIX E

CLIENT HISTORY FORM

CLIENT HISTORY

PLEASE PRINT

Name_____D.O.B._____ Present Age_____

Address_____

Phone_____Bus. Phone_____Place of Birth_____

Marital Status_____Occupation_____

Physician_____Address_____Phone_____

Source of Referral_____Presenting Problem_____

_____

_____

_____

Names of others household	Age	Relationship	Grade in school or Occupation
1._____	____	_____	_____
2._____	____	_____	_____
3._____	____	_____	_____
4._____	____	_____	_____
5._____	____	_____	_____

Highest grade completed in school_____

Number of years married_____Number of previous marriages_____

How were marriages terminated?_____

Baptismal religion_____Current religious orientation_____

Active_____

Occupation_____Years in present employment_____

Previous employment _____ Number of years_____

Gross weekly income _____Household annual income_____

Mother's name _____Age_____Living_____Deceased_____

Occupation_____Religion_____Active_____

Father's name_____Age_____Living_____Deceased_____

Occupation_____Religion_____Active_____

Siblings birth order

Name_____Age_____ Name_____Age_____

Name_____Age_____ Name_____Age_____

Name_____Age_____ Name_____Age_____
(If deceased, place an X by their name)

Describe the positive and negative aspects of your relationship with your parents.

Describe the positive and negative aspects of your relationship with your siblings

1. List any major illness, hospitalizations, or traumtic events that have occurred during your life.

2. What is the current status of your health?_____

_____

3. Have you ever been hospitalized, or treated for emotional or nervous problems? Yes____No____

Hospital	Address, city and state	Dates
_____	_____	_____
_____	_____	_____

4. Have you ever received counseling or outpatient psychiatric treatment? Yes____No____

Therapist/physican	Address, city and state	Dates
_____	_____	_____
_____	_____	_____

5. Have you ever used medication prescribed by a doctor for emotional problems? Yes____No____

Names and amount of medication	Doctor/address	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

APPENDIX F

CONTRACT FORM

Client _____ Therapist _____

Date _____ Title _____

Address_____ Academic
_____ Organization_____

Client-Therapist Agreement

The purpose of this research is to conduct an experiment on the use of guided imagery in psychotherapy on depression. The following are the services that will be offered to the client.

-The client will be scheduled to take part in a guided imagery experiment which will require six sessions of 60 minutes each as well as an initial 90 minute intake session for evaluation and testing.

-The client will be asked to make self-observations three times a week and submit these by mail.

-The client will be given the option of discontinuing treatment at any time with no prejudice to the client.

-Data will be collected and presented in a report which will not reveal the identity of the client.

_____
Clinician/Date

I _____(above named client) understand the terms of this agreement and accept the conditions described above. I also understand that I may withdraw from this treatment at any time without prejudice to myself.

I further assert that the above conditions were discussed fully with me and I consent to those techniques and will comply with the terms of the agreement by providing the data asked of me.

I also assert that I will make the following compensation to the therapist for these services at $10.00 per session.

I understand that my privacy and confidentiality in all these treatments will not be revealed unless I offer my specific written permission.

_____
Client/Date

APPENDIX G

SELF-REPORT FORM

Day_____ 7P.M.

Date_____ Client #____

Please circle one answer code for each statement.

	Not at all	A little	Some	Quite a lot	Very
1. Today, I was emotional	1	2	3	4	5
2. Today, I was happy	1	2	3	4	5
3. Today, I had the blahs	1	2	3	4	5
4. Today, I felt vigorous	1	2	3	4	5
5. Today, I felt alive	1	2	3	4	5
6. Today, I was bored	1	2	3	4	5
7. Last night, I slept like a log	1	2	3	4	5
8. Last night, I slept poorly	1	2	3	4	5
9. Today, I was uptight	1	2	3	4	5
10.Today, I felt serene	1	2	3	4	5
11.Today, my thoughts were dark and gloomy	1	2	3	4	5
12.Today, I felt full of life	1	2	3	4	5
13.Today, I had feelings of remorse	1	2	3	4	5
14.Today, I felt important	1	2	3	4	5
15.Today, I could focus on my work easily	1	2	3	4	5
16.Today, I was easily distracted	1	2	3	4	5

APPENDIX H

CASE STUDY

CASE STUDY

The subject is an eighteen year old male who came for therapy on his own volition to rid himself of the guilt and shame he felt for having sexually abused young children. He was also feeling suicidal and was experiencing difficulties in a relationship. At age fourteen, he sexually abused two young children. Department of Youth Services became involved and eventually he was placed on probation and received mandated counseling for a year. The subject had been out of school since the age of sixteen. He supports himself but still lives at home with an intact family. He volunteered for the research program and was placed in the delayed program. He was diagnosed as extremely-severely depressed on the Beck Depression Inventory in the initial interview. The subject seemed a normally developed eighteen year old. He denied drug use and appeared to be normal in speech and thought processes. He seemed eager for therapy, butr said that he could wait the six weeks before treatment. He made a promise not to act out suicidal ideation.

During treatment he relates that he was sexually abused by a baby sitter at six years of age and never shared this with anyone. Later in the process of treatment, he admits to the use of drugs and alcohol. By the end of treatment, he joined the program of Alcoholic

Anonymous and has sobriety. Selected portions of the therapy sessions which include guided imagery are presented on the next page. It should be noted, however, that all pauses and periods of silence have been omitted from the following transcript to allow for easier reading.

Therapist: Probably the pain is because you haven't forgiven yourself. Can you accept God's forgiveness?

Client: I think so.

Therapist: What we're going to do now is guided imagery. I'd like you to sit here, and I'm going to sit here. This is all part of the treatment. Now, I'll turn off the lights. I'm going to say a little prayer also. This prayer kind of connotates the presence of God. We are coming before God the Father and we invite Him to be here as the Creator to create new circumstances in our life and now we turn to Jesus and Jesus will turn human as God is human and invoke the sword and experience our pain and experience our suffering and He knows our suffering because He wanted to be obedient to God. He took up the cross and when he did that he said "I will be obedient to God," but He understood how much suffering it would mean. He was also being very obedient to the Father when He was led to be crucified. As He was led, He was tortured, He was gorged. But He withstood that pain all the way to the Cross where He died for us so that we could be free,

so we could have life. And He died and He gave us the gift of love -- forgiveness -- and when we turn to Jesus, and say, "Jesus forgive me ", He forgives us right away. So let us turn to Jesus and repent our sins. And he gave us the gift of the Holy Spirit, and we're praying to the Holy Trinity, and we ask that Jesus with God look over you and your family and protect them from any harm and ask Jesus ?????????and we ask that despite all the powers coming from the ministry ?????? and we ask Jesus' protection and that His angels protect us from evil. Now you haven't said anything about your parents at all. So what we'll do is talk about your parents next, okay? What I want to do is get into what happened before, what you went through as a child, and for that purpose I ask the Holy Spirit to come and guide me to give you direction and wisdom and that the Holy Spirit bring that to life. Now what I sense is that you've never felt God's total forgiveness, and that's what I think you need to go through as a prayer for yourself, and also what I think... let me ask you something, did you ever get involved in anything of the occult? Ouijui boards?

Client: I played with the ouiji board, but I never believed in it, I tried it, but it never worked. I found out later how it worked, but I never thought of it.

Therapist: Did you ever go to meetings, pulling up the spirits, um,

Client: Satanism, no, no Satanism.

Therapist: What made you stay away from that? Did you see kids at school doing it?

Client: No, most of my friends were nice kids. They were okay.

Therapist: Well, let me see if, what I would like to do now is go back to the time when you were being abused and let Jesus come in and be the healer, okay? Do you visualize Jesus?

Client: No.

Therapist: Have you ever visualized Him?

Client: I've tried.

Therapist: And then what happens?

Client: I don't see Him.

Therapist: Do you see light at all? Do you see anything? Why don't you close your eyes for a second, okay? Do you trust me? Okay, close your eyes, and take a deep breath. Now here's the deep breath you take, I'm going to show you

how to do it, okay? Take a deep breath like this and then let it out real slow. Can you do that?

Client: Yeah.

Therapist: It's different isn't it, it relaxes your body. Okay, now do it three times. Okay? Now you tightened your muscles when you did that, you have to relax. Now think of these muscles turning to water, relax your whole body. You're starting the pace in your upper body, now just let go, relax right, okay?

Client: Should I take another deep breath?

Therapist: Well, you can take one. Now I want you to picture the incident that happened to you as a child, and when you have it all in your mind, try to describe the room.

Client: It was the basement.

Therapist: In the basement, okay, what do you see around you?

Client: Darkness.

Therapist: Do you feel anything happening to your body?.....Now it might have been pleasure. Sometimes it seems pleasurable. Do you feel shame. Now there was a certain amount of shame when I came in here. Did you feel guilt?

Therapist: Did anything else peculiar happen to you as a child? Do you remember anything else that happened to you as a child?

Client: Not really. I used to take showers with my mother. She used to let me in the shower with her.

Therapist: Did anything happen to you in the shower?

Client: Not that I remember.

Therapist: How old were you when you were taking showers with your mother?

Client: Up to probably four years old.

Therapist: Do you remember anything?

Client: No, I don't remember. No, I just know. I don't see myself in the shower with her. I don't remember any certain time being in there, you know I just took a shower.

Therapist: Um, you don't remember anything else that happened as a child? You don't remember seeing anything?

Client: I remember one other time another kid looking through some porno book. I can remember looking at them. Another kid my age was buying them.

Therapist: How old were you then?

Client: Between six and eight years old.

Therapist: Were you fascinated with sexual things?

Client: I think I was then.

Therapist: Were you thinking sexual thoughts at that age?

Client: Excuse me.

Therapist: Were you thinking sexual thoughts at an early age?

Client: Yeah. One of my friends found out and told me when I was about six years old basically how you make babies.

Therapist: That must have shocked you.

Client: (Laughing) He was a lot older than I was, he was probably about 10 years old. Big age difference, you know.

Therapist: He knew all about it, huh? We'll see how well you do so far, okay. In the Name of the Father, and of the Son, and of the Holy Spirit, I ask you Jesus to seal up the healing that has taken place here today. Please forgive this boy. Did you accept Jesus while you were under, you did, you have? Did you? If I said to you, did you accept Jesus in your heart, what would you say?

Client: Not really, I wanted him to come in.

Therapist: Okay, why don't you just say, "Jesus come into my heart."

Client: Jesus come into my heart.

Therapist: And stay there for ever and ever. Now, I noticed that there's some movement in your muscles. Do you have some muscle movement in your body that sometimes comes on its own.

Client: Yeah, some.

Therapist: When did that start, do you know?

Client: I think just a few years ago, but my legs used to shake. I would just be sitting normal and they'd start.

Therapist: To shake.

Client: Yeah, like this.

Therapist: What about your chest? Were there muscle movements in your chest?

Client: Sometimes. Lots of times when I'm just about ready to go to sleep, I'll get like a shock or something.

Therapist: A jerk?

Client: Yeah. Sometimes it would affect my arms. Just a little while ago something like this.

Therapist: We'll talk more about that, okay? All right, how does it feel the first session? Scared?

Client: A little bit.

Therapist: Okay.

APPENDIX I

MEANS

Means ($\bar{X}$) of Graphs of Delayed Cases

Case #	Mean ($\bar{X}$) of individual (all) scores	Mean ($\bar{X}$) of non-intervention scores	Mean ($\bar{X}$) of intervention scores
13	39.2	37.9	40.8
15	43.8	43.75	43.85
18	47.53	41.33	52.0
20	39.22	41.47	37.47
21	48.85	55.68	42.77
27	48.27	43.72	48.27
31	39.86	41.33	38.27
33	25.36	26.85	23.45

Means ($\bar{X}$) of Graphs of Non-delayed Cases

Case #	Mean ($\bar{X}$) of individual (all) scores	Mean ($\bar{X}$) of intervention scores	Mean ($\bar{X}$) of non-intervention scores
12	55.9	55.6	59.25
14	44.19	46.8	39.8
16	50.22	50.85	49.3
17	49.46	50.55	45.3
19	30.5	31.4	29.4
22	41.07	46.22	32.0
25	50.46	56.69	46.86
26	50.5	54.7	47.8
28	55.5	57.93	53.66
32	48.27	46.9	49.4

APPENDIX J

QUESTIONS & ANSWERS

Evaluation Questions and Answers

Question 1: In what way did the counseling help you?

Case #

12. Made me more aware.

13. Just talking to her helped, the healing part was relieving.

14. Helped me in many ways such as my relationship to my wife, and to my son, and to my friends, also to the world in general.

15. Some help, doesn't know.

16. It made me feel less than alone that someone was willing to be there for me.

17. It helped me get in touch with reality, and put my abilities and failures in proper perspective.

18. It helped me face painful issues. It helped talking things out.

19. Counseling has helped me in many ways. First, it helped me take a look at myself and to see that I'm not a bad person. I can "see the whole picture" when making decisions, and my relationship with my husband and family has improved. My attitude has also been uplifted.

20. It helps to take a look at things from an objective viewpoint.

21. In every way! I feel very different about myself in a very positive sense.

22. It helped strengthen faith in myself.

25. Being able to verbalize a lot of pent-up feelings and thoughts I felt would overburden my spouse.

26. It's given me a base; a touchpoint to know there's someone who understands and isn't being negatively judgmental of me.

27. By looking at and feeling the past hurts and mistakes.

28. Improved my spirits and hope. Adds joy to my life. I was able to work through and talk about some issues.

31. In a very profound way it opened my mind's eye to being receptive to another's concepts. It also aided me in establishing more firm connections between who I am, today, and how my childhood experiences caused that person, who I am today, exist.

32. Gave encouragement that God has heard my prayers and is healing not only me, but my family. Gave me insight as to why my family and I have experienced some of the problems we have.

33. Guidance, itemize certain things, I had a lot of mixed feelings and guidance gave me straightforward answers.

Question 2: Among the different techniques used by your therapist, which ones did you like the best?

Case #:

12. Prayer.

13. Imagery; Healing.

14. Going back to childhood and also by having myself in situations with my mind going in different places.

15. Don't remember.

16. When I visualized Jesus with me.

17. Prayer. Visual imagery.

18. Prayer.

19. I think that when something is bothering you, and you and your therapist are in prayer, looking at the problem and imagining that Jesus steps in and looks at you, and then makes you feel all better and takes the hurt away. That's what I like best.

20. Honesty; Trustworthiness.

21. Praying was #1, and putting me back into the past with Jesus.

22. Talking openly, especially getting Christ into everyday living.

25. Including God in the healing process.

26. Specific "tools," suggestions given of way to be actively involved in my recovery process.

27. Prayer and Imagery.

28. Visualization.

31. Imagery, particularly in dealing with the child within. I now find myself much more aware of the existence of this child.

32. Prayer.

33. Enjoyed the prayer immmensely.

Question 3: What was the worst part of therapy?

Case #:

12. Dealing with father, past relationships.

13. Telling her my problems.

14. Having to confront the truth.

15. Don't know.

16. Talking about some hurtful things.

17. Not always enough time.

18. Feeling the pain and feeling overwhelmed by it sometimes.

19. Driving there!

20. No response to this question.

21. Remembering and facing truths.

22. Overcoming the guilt of not working.

25. Coming to terms with underlying guilt feelings.

26. Brevity of number of sessions.

27. Some of the feelings that came out.

28. Being verbally attacked by the therapist, putting up with disorganization of therapist. Telephone being answered during the hour visit.

31. My own resistance to conceptualizations which conflicted with preheld biases on my part.

32. Waiting for the results in my own life.

33. None.

Question 4: In what way did your depression improve, increase or stay the same?

Case #:

12. During therapy I felt better.

13. My depression improved a lot because I have someone to talk to and someone that I know cares.

14. My depression improved to the fact that I did not want to face another day.

15. Never thought I was depressed to begin with.

16. I at least have some hope for the future.

17. Great improvement: 1. More positive. 2. Less self deprecating. 3. Far more motivated to do everyday living rather than staying in bed and doing nothing.

18. Sometimes it seems improved, and other times worse.

19. I wasn't really depressed when I started therapy. But I think and feel that my attitude and thoughts have taken a turn for the best.

20. I have a more positive attitude and a little more tolerance of others.

21. What depression? HA!HA! Just kidding, I left for good and I feel "new."

22. By learning to <u>accept</u> life's problems and not taking them personally.

25. It seems to fluctuate, depending on how well I seem to be progressing, at what I'm doing or trying to accomplish.

26. I became more aware of it and its intensity.

27. Mostly seems to go up and down about the same, due to present situation, but not as bad, has improved.

28. Improved. 1. Increased medication by M.D. 2. The entering of Christ into my life more fully. 3. My health started to improve. 4. Sunlight days getting longer. 5. Accupuncture and P.T.

31. Can not speak directly to depression, but I do feel that "cause and effect" are now more concrete for me.

32. I am more hopeful about the future even though I still feel sad and irritable much of the time.

33. Depression improved. Have more of a handle on it.

Question 5: Did the prayer each session help, and if so, in what way?

Case #:

12. Gave me a little more faith.

13. Yes because it released a lot of tension and it got me thinking into improving my life. I think it's a start.

14. Prayer helped each time, for it gave me a peace that Jesus was involved in each session.

15. Didn't help.

16. Yes, prayer always helps. It gives me peace.

17. Yes, I felt the love of Jesus -- I felt the comfort and peace of Jesus and I am grateful!

18. Yes, I felt the peace of Jesus.

19. Yes! The prayer was an important part. I felt closer to Jesus and I feel more comfortable talking about and praying to Jesus.

20. Yes, it helps to think about how God can affect your life.

21. Yes it helped, it put me in touch with God in a new way -- I knew He was in charge. I never thought praying could produce such mighty stuff.

22. Yes it calmed me. But, it also made me realize how hard I had been fighting Christ.

25. Yes, because I have great difficulty speaking to God when I need Him most.

26. Yes, I felt action being taken.

27. Knowing and feeling that God is there also, to help and heal.

28. Yes, I'm not sure in what way. I look forward to and enjoy the prayers.

31. I wanted prayer to help, but I have a strong sense of defeating that purpose through my own resistance.

32. It assured me that God knows exactly what is needed, that He loves me, and that His power is healing me.

33. For the better.

Question 6: Would you recommend the kinds of things your therapist used to a friend with similar issues as yours?

Case #:

12. Yes.

13. Yes.

14. Yes, but getting them to understand that they need help is a little bit difficult at best.

15. Sure!

16. Definitely.

17. By all means, 100%.

18. Yes.

19. Yes! Just being able to talk to someone who will really listen and then give you input is a big relief. Also the understanding and kindness also helps.

20. Yes.

21. Yes!

14. Yes, but getting

22. Yes.

25. Definitely.

26. Yes.

28. Yes.

31. Yes; just the feeling of being comfortable sharing and talking things out with someone who has professional insight is very rewarding.

32. Yes.

33. Yes.

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